Beneficiary Profile

1. Name of person establishing Trust (Sponsor):

_____

Relationship to Beneficiary:
□ Self (skip to #2)
□ Parent
□ Grandparent
□ Legal Guardian
□ Court Ordered

Address of Sponsor: _____

_____

Sponsor Telephone: ( ) _____-_____ Sponsor email:_____

2. Beneficiary Name: _____
(Please include middle initial)

Social Security #: _____-_____-_____

Address: _____

_____

County of Residence: _____

Telephone: (day) _____evening:_____

Beneficiary Email:_____

Citizenship: _____

Date of Birth: _____ Gender: Male____ Female ___ Not Specified___

Disability Diagnosis: _____

3. Reason for establishing Trust:
☐ Monthly Spend Down _____ estimated amount *
☐ Inheritance
☐ Social Security Back Payments
☐ Settlement
☐ Savings
**Note: This is supplemental information for FCPS only. This amount may be changed at anytime with no effect on the Sponsor Agreement*

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4. **Beneficiary Income:** circle either yes or no for each potential source of income

Social Security Disability (SSD)	YES	NO
Disabled Adult Child (DAC) benefits	YES	NO
Social Security Retirement Income (SSA)	YES	NO
Supplemental Security Income (SSI)	YES	NO
Other income	YES	NO

Specify type of other income:

_____
_____
_____
_____
_____

Other benefits or entitlements, (such as food stamps, HUD Sec. 8, etc.) list these benefits and monthly amounts.

_____
_____
_____

Does the Beneficiary receive Medicaid? _____YES _____NO _____Pending

If YES, provide Medicaid number _____

If Pending, Date application sent to DHS: _____ Status of application:_____

5. **Beneficiary living arrangement**:

Lives independently _____ Lives w/ parents or other family_____
in household _____
Family Care Program _____ CR/IRA/ICF (supervised) _____
CR/IRA (supportive) _____ Nursing Home _____
Assisted Living Facility _____

6. **Beneficiary Services (include day services, service coordination, employment programs etc.)**

Service	**Name of Provider**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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7. Is there a court appointed Guardian for the Beneficiary? YES _____ NO_____

If yes, **attach a copy of decree and Letters of Guardianship**

List name(s) and address(s) of Guardians:

_____
_____
_____

8. ***FCPS requires the Beneficiary to have an authorized contact to speak to us on your behalf. If you do not wish to receive monthly statements, please identify one of your contacts to receive on your behalf.***

List authorized persons:

☐ Permission to Submit Disbursement Request Forms
☐ May receive Account Statements and Tax Information (rather than yourself)
Name: _____
Address: _____
Relationship: _____
Work phone_____
Home phone_____
Cell phone _____
E-mail _____

☐ Permission to Submit Disbursement Request Forms
☐ May receive Account Statements and Tax Information (rather than yourself)
Name: _____
Address: _____
Relationship: _____
Work phone_____
Home phone_____
Cell phone _____
E-mail _____

☐ Permission to Submit Disbursement Request Forms
☐ May receive Account Statements and Tax Information (rather than yourself)
Name: _____
Address: _____
Relationship: _____
Work phone_____
Home phone_____
Cell phone _____
E-mail _____

Beneficiary Profile

9. Name and address of person/agency who will be submitting the Trust documents to Medicaid (DHS), Social Security Administration, or other government agencies on your behalf:

Name: _____
Agency: _____
Address: _____
Work phone_____
E-mail _____

10. Does the Beneficiary have funeral provisions in place (pre-paid funeral, burial plot etc?)

YES _____ NO _____

If yes, give name and addresses of cemetery and funeral home:
Cemetery:
_____
_____
Funeral Home:
_____
_____

11. Is there a life insurance policy in place for the Beneficiary? YES ___ NO ____

If yes: Name of Insurance Company_____
Address: _____
Policy #: _____

I certify the above information is accurate and complete to the best of my knowledge.

_____

_____

Sponsor/Beneficiary Signature Date_____