

**Trust Intake Form**

**General Information:**

Full Legal Name of Trust: \_\_\_\_\_  
EIN#: \_\_\_\_\_  
Trustee: \_\_\_\_\_  
Beneficiary: \_\_\_\_\_  
Date Established: \_\_\_\_\_ Established By: \_\_\_\_\_  
Source of Funds: \_\_\_\_\_ Approximate value of Trust Assets: \_\_\_\_\_  
Attorney Contact: \_\_\_\_\_  
Case Docket No.: \_\_\_\_\_

**Beneficiary Information:**

Name: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_  
Other Family Members: \_\_\_\_\_  
Residence Address: \_\_\_\_\_  
Home \_\_\_\_ Group Home \_\_\_\_ Other \_\_\_\_\_  
General Nature of Disability: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Nature of Impairments: \_\_\_\_\_  
Does the Beneficiary have any of the following:  
Will \_\_\_\_ Guardian \_\_\_\_ Power of Attorney \_\_\_\_ Conservator \_\_\_\_ Healthcare Directive \_\_\_\_

**Benefits Qualifications:**

Public Benefits:  
\_\_\_\_ SSI                      \_\_\_\_ VA Benefits  
\_\_\_\_ SSDI                     \_\_\_\_ Subsidized Housing  
\_\_\_\_ Medicaid                \_\_\_\_ Food Stamps  
\_\_\_\_ Medicare                \_\_\_\_ DDSN Services  
\_\_\_\_ Other: \_\_\_\_\_

\*If yes, supply numbers/obtain copy of card.

State specific benefits: \_\_\_\_\_  
Private Insurance:  
\_\_\_\_ Medicare Supplement      \_\_\_\_ Long Term Care Insurance  
\_\_\_\_ Long Term Disability        \_\_\_\_ Private Health Insurance  
\_\_\_\_ Other: \_\_\_\_\_