DIRECTED BENEFITS foundation
Where passion meets purpose.

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: _____