LIFE PLAN OF KENTUCKY, INC.

Beneficiary Background Information

Date completed: _____

Full Name of beneficiary: _____

Beneficiary prefers to be called: _____

Birth date: _____ Birth place_____
City, State, Country if not U.S.A.

Social Security Number: _____

Beneficiary Contact Information		
Check if applicable: □ **Do NOT communicate directly with beneficiary**		
Address:		
City:	State:	Zip:
Telephone: (Day #) (Evening #)		Fax:
Email		

Please describe your disability and its impact on your life in your own words:

_____
_____
_____

Does your disability have a medical diagnosis? If so, can you tell us what it is and how you think it will impact your future?

_____
_____
_____
_____

What is important to you in your life that you hope these funds will help you maintain or accomplish? _____

_____

_____

What is important for you in your life to stay healthy and safe that you hope these funds will support or provide? _____

_____

_____

1. Is this trust established by court order? YES □ NO □
   **include a copy of court order.*
2. What is the source of funds for the trust?
   - □ **Funds of the third party settlor** (not beneficiary).
     **Family gift, inheritance paying directly to trust, life insurance directly to trust.*
   - □ **Funds of the beneficiary** - From a personal injury settlement.
     **include a copy of this settlement, including but not limited to annuity schedule and future deposit amounts expected with dates.*
   - □ **Funds of the beneficiary** - Inheritance.
     **Include a copy of Last Will and Testament of the deceased.*
   - □ **Funds of the beneficiary** - Social Security back pay or retroactive payment.
   - □ **Funds of the beneficiary** - Conserved funds, life insurance payout or other fund.

For trusts funded with a personal injury settlement ONLY.

Type of damages	Amount of Settlement
Punitive	
Compensatory	
Annuity	
Total settlement amount	

For trusts funded with an Inheritance ONLY:

Name of Estate	
Will a Schedule K-1 be issued from the estate?	YES □ NO □
For Which Tax Year (s)	
Total Amount of distribution to trust from estate	

For trusts funded as a beneficiary of a Retirement ONLY:

Name of Retirement Account	

Will a Schedule K-1 be issued?	YES □ NO □
For Which Tax Year (s)	
Total amount of distribution to Trust	
Will a 1099 be issued?	YES □ NO □

3. What is the beneficiary's disability?
   - □ Developmental disability
   - □ Mental illness
   - □ Brain injury/spinal cord Injury
   - □ Physical disability - specify_____

4. Date of Social Security Administration Disability Determination_____

5. What is the beneficiary's current living arrangement?
   - □ Lives alone
   - □ Lives with family

List names, relationship, and age of others in household

_____
_____
_____

   - □ Lives in a care facility
     - □ Staffed Residence
     - □ Group Home
     - □ ICF (Intermediate Care Facilty)
     - □ RCF (Residential Care Facility)
     - □ SNF (Skilled Nursing Facility - Nursing Home)
     - □ Other State operated facility - Specify_____
     - □ Other - Specify_____

6. If applicable, please enter address of facility where the beneficiary resides:

Facility Name:		
Address:		
City:	State:	Zip:
Telephone:	Fax:	
Staff Contact Name:		
Email:		

7. List the key agencies that provide service to the beneficiary:

**** Examples of agencies include, but are not limited to, home health care, transportation, vocational, or case management services, Not necessary to list Social security or Medicaid in this section.***

Agency Name:		
Address:		
City:	State:	Zip:
Contact Person:	Email:	
Telephone:	Fax:	

Agency Name:		
Address:		
City:	State:	Zip:
Contact Person:	Email:	
Telephone:	Fax:	

Agency Name:		
Address:		
City:	State:	Zip:
Contact Person:	Email:	
Telephone:	Fax:	

8. What sources of income does the beneficiary currently receive?

****Include a copy of the first award letter and/or the most recent Social Security Administration letter.***

Income	**Monthly Amount**
Supplemental Security Income (**SSI**) Date check or deposit is issued monthly:	
Social Security Disability Income (**SSDI**) Date check or deposit is issued monthly: _____ Based on Beneficiary's work record or parent's? _____	

Social Security Retirement Income **(RSDI)**[1] Date check or deposit is issued monthly: _____ Based on Beneficiary's work record or parent's? _____	
Employment (Include 2 pay stubs)	
Veterans Administration Aid and Attendance Benefits	
Other - Specify[1]	
Total Cash Income	

9. What other benefits and services does the Beneficiary receive?

Medicare	
Medigap Supplement	
Name of Company	
Part D Prescription Coverage	
Name of Company	
Extra Help	
Low income housing (section 8) List amount of subsidy	
Food Stamps	
Hart Supported Living	
Kentucky Transitions	
Supports for Community living Waiver	
Michelle P Waiver	
Home & Community Based Waiver	
Acquired Brain Injury Waiver	

[1]Examples of other income sources: retirement accounts and pensions. Please include verification of this income including whose name the pension is under and annuity amounts if applicable.

Acquired Brain Injury Long Term Waiver	
Model II Waiver	
Nursing Home (ICF) - Medicaid	
ICF / IDD - Medicaid	

10. What assets does the Beneficiary own?

Assets owned by Beneficiary	Check response	Approx. Value
House (individually or joint)	YES □ NO □	
Vehicle(s) (year/make/model)	YES □ NO □	
Checking account	YES □ NO □	
Savings account	YES □ NO □	
Pre-paid burial or funeral plan	YES □ NO □	
Annuity	YES □ NO □	
Other - specify	YES □ NO □	

11. Is the beneficiary eligible for or does the beneficiary receive other public benefits or private insurance coverage?
**Provide verification of benefits, including but not limited to: copies of insurance cards, and approval letters.*

Type of Public Benefit or Other Resources	**State(s) Where Benefits Were Received**	**YES/NO**
Medicaid		
Medicaid Waiver Program - Specify[2]		
Other Medicaid Program(s) - Specify[3]		
Medicare		
Private Health Insurance - Specify		
Housing Assistance (HUD)		
Other - Specify		

[2]Including but not limited to Michelle P, Supports for Community Living, Home and Community Based Waiver, etc.
[3]Including but not limited to TANF, child care and Food Stamps.

12. Has the court appointed a legal guardian[4] or conservator[5] for the beneficiary? YES□ NO□

**if so, provide information below and copies of letters of Guardianship and Conservatorship, also called letters of adjudication.*

Check all that Apply: □ Full Guardianship □ Limited Guardianship	□ Full Conservatorship □ Limited Conservatorship
Court that appointed:	
Court Case Number:	
Guardian's Name:	
Social Security # or EIN:	
Address:	
City: State: Zip:	
Email address:	Relationship to Beneficiary

13. Has the Social Security Administration appointed a Representative Payee[6]?

Representative Payee Name:	
Address:	
City: State: Zip:	
Telephone	Fax:

14. Has the life beneficiary executed a Durable Power of Attorney[7]?

**Submit copy of document with signatures. Please note that the Durable Power of Attorney (DPOA) is authorized to sign the trust agreements to establish a trust only if the DPOA specifically delineates powers to open, revoke, or terminate a trust.*

Name:	
Addess:	
City: State: Zip:	
Telephone:	Email:

[4]Guardian - **Court appointed** representative in charge of the beneficiary's well being (often, a guardian has the legal authority to give and sign medical consents, sign contracts, and where the beneficiary shall reside).

[5]Conservator - **Court appointed** representative in charge of the beneficiary's financial affairs and decisions.

[6]A Representative Payee is a person or agency appointed by the Social Security Administration to receive the Social Security benefits of the beneficiary. This person does not have the legal authority as a guardian, conservator, or power of attorney.

[7]A Power of Attorney is authorized by an individual to make healthcare or financial decisions as outlined in the notarized document designating the party. May also be called Attorney in Fact. Power of Attorney is and ***NOT*** a guardian or conservator.

15. For Third Party Trusts Only: Complete the following information for the Settlor (s).

Full name of Settlor	Relationship to Beneficiary	Telephone	Fax	Email

16. Provide contact information for Remainder Beneficiaries:

Full Name(s) of Remainder Beneficiary (ies)	Relationship to Beneficiary	Telephone	Fax	Email

17. How did you learn About Life Plan?

□ Attorney Referral - Name_____

□ Resource Fair Conference Exhibit - Name_____

□ Internet Site_____

□ Service or Agency Representative - Name_____

□ Print ads or Legal Directory - Name_____

□ Other - Specify_____

_____ _____

Signature of Person Completing Form Date

_____ _____

Print Name of Person Completing Form Phone