INSTRUCTIONS FOR COMPLETING THE OPENING ACCOUNT FORM

The information provided will remain confidential. Please fill out each section. Note that some sections may not be applicable to you and may remain blank. If you have any questions, please contact ACT at 610-265-4788, or info@arctrust.org

Step 1)

- Provide complete information about the Beneficiary.
- If applicable, mark the **type of Income** that the beneficiary receives.
- Identify the type of Health Insurance that the beneficiary has.
- List information about the beneficiary's **Parents**. You **MUST** provide details of at least one parent if the beneficiary is a minor. The SSN can be helpful in the event the person may be eligible for
- If applicable, list the **Rep Payee, Power of Attorney, or Court-Appointed Guardian**. Please include copies of the relevant documents for our file.
- If applicable, identify the Coordinator and Other Services received by the beneficiary.

Step 2)

- **Identify the Settlor**, the person or entity that is creating the trust. Please be sure to **provide the Settlor's SSN and a copy of Driver's License or Passport as photo identification**. If the Settlor is deceased, please provide the decedent's SSN or Estate EIN. If the trust is funded from an education settlement, provide the School's information, to include its EIN. These numbers are required in order for ACT to obtain an EIN for the trust.
- If known, provide the name and address of the **Attorney** who assisted you.

Step 3)

- Provide information about **Funding of Account**.
- List the name and address of the individual(s) who will receive Account Statements. These may be sent to more than one individual. **This section must have at least one person listed**.
- This section must identify the name and address of one individual who will receive Tax Information for the beneficiary's personal income tax return. This can be a paid tax preparer, the beneficiary, or a family member. Transfers into the Trust are not tax deductible. The Trustee will issue appropriate Federal and State tax forms on a yearly basis. Beneficiaries should consult with their own tax advisor regarding their personal tax returns.
- If applicable, list any prepaid **Final Arrangements** for the Beneficiary. If none are currently established, please contact ACT for assistance in setting up arrangements.

Carefully read through the Disclosure Statement. Date and sign the document. Send the form to ACT with other relevant documents, **including Court Orders/Petitions, Wills, annuity contracts, etc**. If the Settlor is a Court-appointed Guardian, he or she must sign for the Beneficiary.

ACT will send a Welcome Packet to the Settlor after the Trust is opened. The packet will include letters for the Beneficiary to send to the Social Security Administration and the Department of Human Services, as well as additional forms and information to help the Beneficiary.

THE ARC COMMUNITY TRUST OF PENNSYLVANIA

The following information is **REQUIRED** to open a new trust account. Please complete applicable sections with **as much detail as you can**. If applicable, attach copies of relevant documents, including Court Orders/Petitions, Wills, annuity contracts, etc.

NEW TRUST OPENING ACCOUNT FORM
THIRD PARTY AND PAYBACK

STEP 1)

1. BENEFICIARY

Name _____

Address _____

_____

Telephone: Day_____Evening _____

Social Security Number _____

Date of Birth: _____

Place of Birth (Hospital, City, State): _____

Gender:_____

Lives: ☐ Alone ☐ With parents/guardian ☐ Group Home (supply name):

Other: If the Beneficiary is not living on their own, please describe the living arrangement (e.g. who is responsible for the living arrangements, who else lives with the beneficiary etc.)

_____

_____

2. INCOME AND BENEFITS

Please indicate whether Beneficiary receives any of the following benefits:

SSI ID#_____Monthly amount _____

SSDI ID#_____Monthly amount _____ SS

Retirement ID#_____monthly amount _____

SS Survivors ID#_____monthly amount_____ Medicaid

(Access Card)_____card number _____

Please list **OTHER** forms and amounts of government assistance.

Veterans Administration: ☐ Monthly Amount:

Railroad Retirement: ☐ Monthly Amount:

Public Assistance: ☐ Monthly Amount:

Wages: ☐ Monthly Amount:

Employer:

Pension: ☐ Former Employer: Monthly Amount:

Other: ☐ Type of Income: Monthly Amount:

Type of Income: Monthly Amount:

3. DISABILITY

Please provide the following information on the Beneficiary's disability(ies):

Nature of the disability(ies)

_____

Medical diagnosis, if available

Prognosis or plans

Name and address of primary care physician and, if appropriate, psychiatrist

4. HEALTH/MEDICAL INSURANCE

Please indicate any health insurance coverage for the beneficiary and supply identification numbers, if known.

Medicare ☐ Identification Number: _____

Medical Assistance ☐ Identification Number: _____

Medicaid Waiver ☐ Identification Number: _____

Other: ☐ Name of Provider: _____

Policy No: _____

Please list any health insurance policies (other than Medicaid and including Medicare).

Insurer_____

Address_____

Policy Number _____

Insurer_____

Address_____

Policy Number _____

5. **PARENTS, GUARDIANS OR REPRESENTATIVES**

Name and Relationship _____

Address _____

_____

Telephone: Day_____Evening _____

Name and Relationship _____

Address _____

_____

Telephone: Day_____Evening _____

Relationship _____

For any others, please use additional pages.

6. **GOALS FOR FUND:**

How do you expect the fund to be used?
(Please indicate specific expenses you anticipate paying from the fund).

_____

_____

How long do you expect the fund to last to be available to meet those expenses?

_____

_____

When do you expect to begin to use the fund? _____

STEP 2)

7. **GRANTOR/SETTLOR**

Name _____

Address _____

_____

Telephone: Day_____Evening _____

SSN, Estate EIN, or School EIN _____

Date of Birth _____

Relationship to Beneficiary _____

Note: If there is more than one Settlor, please use additional pages for this information.

8. **ATTORNEY**

Name: _____

Address: _____

Telephone Number: _____

Email Address:_____

Fax Number: _____

Note: Provide any relevant information.

STEP3)

9. FUNDING OF ACCOUNT

Amount to be received:

Approximate Date of Funding:

Source of Funds:

Examples: Settlement, Litigation Proceeds, Inheritance, etc.

*** If the trust will receive annuity payments, please provide a copy of the annuity contract as well as a name, address and telephone number for the contact person and payment frequency. ***

What assets will be deposited to the trust and if all funds won't come in at inception, please indicate the expected dates and amounts of subsequent deposits to the Trust.

_____

_____

What is the source of the funds? _____

_____

If the source of funds is a lawsuit or settlement, please identify the Attorney responsible for the resolution of the claim (including firm name, address & telephone no.).

_____

_____

Have all liens associated with any personal injury claim been satisfied?

_____

10. STATEMENT

Please indicate the names and addresses of the individual(s) to receive quarterly statements. Quarterly statements can be sent to multiple individuals.

11. TAX INFORMATION

List the name and address of the individual to receive tax information for filing personal tax returns on behalf of the beneficiary. Only one individual can receive tax information.

12. DEPARTMENT OF HUMAN SERVICES

Has DHS's approval of the Trust been obtained? Y ☐ N ☐

If approval letter not yet been obtained, provide evidence that approval has been sought:

Note: If there is more than one Legal Representative, please use additional pages for this information.

13. FUNERAL PLANS

Please provide the following information if the Beneficiary is covered by any prepaid funeral or burial plan:

Insurer_____

Address_____

Policy Number _____

DISCLOSURE STATEMENT

I have asked The Arc Community Trust of Pennsylvania to serve as trustee of funds.

I understand that those funds will be invested and I acknowledge:

1. That ACT may invest these funds with other funds, but account for them on an individual basis.
2. That these funds are not obligations or guaranteed by ACT.
3. That these funds are not deposits insured by the Federal Deposit Insurance Corporation (FDIC), and are subject to investment risk, including possible loss of principal invested.
4. That ACT adopts investment guidelines for trust funds and those investment guidelines can change at any time.
5. That the market values of investments do fluctuate, and upon liquidation, could be of value more or less than the market value of my original deposit into the trust account.
6. That income earned and retained in my trust account, or received in distributions from my trust account, will fluctuate over time.
7. That past investment performance either reviewed or considered by me is past performance only and not a guarantee of future results.
8. That I have been provided with a copy of the ACT Fee Schedule. I understand that fees charged by the trustee may reduce the principal amount of my trust account.
9. That trusts are taxable. ACT will file fiduciary tax returns for its trusts and may charge my trust account for any taxes owed ACT will also send me tax information to include in my personal tax return.
10. That I am responsible for informing my State's Medicaid office about the trust.

Date: _____ Signature: _____

(Settlor)

Date: _____ Signature: _____

(Beneficiary or Legal Representative)