CCT
Commonwealth Community Trust

Security for People with Special Needs since 1990

office | 804.740.6930 **toll free** | 888.241.6039 **fax** | 804.740.6065
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Family and Beneficiary Information

CONFIDENTIAL INFORMATION: This document will provide background information to assist Commonwealth Community Trust (CCT) staff in understanding your wishes to provide for the Beneficiary. You can complete as much information as you would like, and update the information as needed. It is also recommended that the document be shared with designated Advocate(s), caregiver(s) and other family members, where appropriate.

Completed by: _____

Relationship: _____ Date: _____

Beneficiary Information

Name: _____

Nature of Disability: _____

Probability / Degree of Disability Change: _____

Grantor Information

Name: _____ Relationship: _____

Grantor's Vision for the Trust

Please describe the objectives for the trust, once funded. Feel free to attach additional pages if necessary.

Family Composition

Mother

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Father

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Siblings

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

(If more, continue on additional page.)

Other Significant Individuals

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

(If more, continue on additional page.)

Residential Information

☐ Beneficiary resides on his/her own ☐ House ☐ Apartment ☐ Other: _____

☐ Beneficiary resides in someone else's home Relationship of homeowner: _____

☐ Other (Please provide information if group home, nursing home, or other residential or medical facility)

Type of Residence: _____

Contact Name, if applicable: _____ Relationship: _____

Address/Phone Number: _____

Household Composition

Those currently living with the beneficiary:

Name	Relationship

Is this arrangement expected to continue: ☐ Yes ☐ No Comments: _____

If different arrangements are anticipated in the future:

Conditions: _____

Type of Residence: _____

Name of Contact: _____ Relationship: _____

Address/Phone Number: _____

Other Comments: _____

CCT Named Advocate(s)

The advocate(s) will be responsible for communicating requests to CCT for disbursements and receiving financial information. Advocates are designated on the Joinder Agreement, but keep CCT updated should this or any contact information change. Please complete Change of Advocate Form to change designated Advocate(s).

Agency Information

If the Beneficiary receives public benefits, agency information should be provided on the Joinder Agreement. Please notify CCT as soon as possible of any changes to benefits that the Beneficiary receives, particularly Supplemental Security Income (SSI) and Medicaid, or if the contact information changes for existing benefits.

Beneficiary's Insurance

Please provide Agency/Company name, policy number, contact, address, and telephone, I.D. number, who presently pays the premium, payment schedule, and amount.

Health Insurance

☐ Medicaid ☐ Medicare ☐ Other:

Car Insurance

Life Insurance

Dental Insurance

Other

Medical Information

Describe Beneficiary's Medical Condition (Primary and Secondary Diagnosis):

Special Needs or Instructions:

Personal Physician Information

Does the Beneficiary have a personal physician: ☐ Yes ☐ No

Physician Name: _____ Specialty: _____

Address: _____

Office Number: _____

Names of other Doctor/Dentist/Optometrist/Pharmacy and addresses and telephone:

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

List of Recent Hospitalizations

Name of Hospital	Reason	Dates of Hospitalization

Give specifics for the following where applicable.

☐ Food or Environmental Allergies: _____

☐ Drug Allergies: _____

☐ Other Allergic Agents: _____

☐ Diabetes/family history of diabetes: _____

☐ History of Seizures: (type) _____

☐ High or Low Blood Pressure: _____

☐ Developmental Disabilities: _____

☐ Speech or Hearing Impediments: _____

☐ Orthopedic Problems: _____

☐ Mental Health Issues: _____

☐ Other: _____

Educational Information, Employment History and Present Employability

Educational and/or Training Programs Attended:

Type of Program (e.g. high school, vocational training)	Program	Dates

Has the Beneficiary exhibited any issues that limited participation in school or work? ☐ Yes ☐ No

If Yes, please describe: _____

_____

Do you foresee the Beneficiary utilizing the Trust to pursue educational or vocational goals?

☐ Yes ☐ No

If Yes, please describe: _____

_____

The Beneficiary is:

☐ Capable of self-support through employment
☐ Capable of partial self-support through employment
☐ In need of education or training to be self-supporting through employment
☐ Presently incapable of self-support through employment and the situation

Comments: _____

_____

Financial and Legal Information

The beneficiary is currently receiving monies from:

Family: $ _____ /Month
Employment or Assets: $ _____ /Month
Social Security Benefits: $ _____ /Month
Social Security Benefits for Disabilities: $ _____ /Month
Supplemental Security Income: $ _____ /Month
Other: _____ $ _____ /Month

Does the Beneficiary have a designated payee? ☐ Yes ☐ No

Payee Name: _____ Relationship: _____

Address: _____

Phone Number: _____

What monies does this involve? _____

Does the Beneficiary have a current guardian, qualified in court, or a natural guardian? ☐ Yes ☐ No

Guardian Name: _____ Relationship: _____

Address: _____

Phone Number: _____

Does the Parent/Settler receive benefits (pension, social security, etc.) that will continue for the Beneficiary after the Parents are deceased? ☐ Yes ☐ No

Benefit Details: _____

Wills

Do the Parents/Settlers have a will? ☐ Yes ☐ No

Date will was drawn: _____ Executor: _____

Attorney: _____

Provisions in the will, if any, for the Beneficiary: _____

Location of original will: _____

Is the Beneficiary included in any other person's will or trust bequest? ☐ Yes ☐ No

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Planning for the Future

Please share any relevant information about the Beneficiary's needs and preferences that may help in administering this trust:

Routine Medical Care:

- ☐ Annual Physical Exam
- ☐ Payment of Medical Insurance
- ☐ Eye Exam/Eyeglasses when needed
- ☐ Payment of Dental Insurance
- ☐ Semi-Annual Dental Exam
- ☐ Hearing Exam/Hearing Aid when needed

Other:

Religious Environment: _____

General Care:

☐ Toiletries
☐ Regular haircuts
☐ Telephone/cell phone
☐ Furniture
☐ Games, toys, electronics
☐ Clothing and accessories
☐ Other personal items: _____
☐ Other: _____

Transportation:

☐ Beneficiary should be able to use public transportation with or without supervision
☐ Beneficiary may choose to own and operate his/her own vehicle
☐ Beneficiary may need someone to transport them to appointments and community activities
☐ Other: _____

Recreation and Entertainment:

(Please indicate any specific interests of the Beneficiary that the trust may support in the future.)

☐ Participation in sports and related activities
☐ Attending sporting events
☐ Membership to a gym or community facility
☐ Summer camp, special camps, or community outings
☐ Music lessons or attending concerts
☐ Movies
☐ Amusement parks or museums
☐ Other hobbies/interests: _____

Travel:

☐ Vacation with family or friends
☐ Travel to visit family or friends
☐ Sponsored tours
☐ Other: _____

* Is supervision or a companion required for outings or activities? ☐ Yes ☐ No

Personal Equipment:

☐ Computer
☐ Television, cable services, DVD player
☐ Assistive Technology
☐ Stereo, iPod
☐ Other: _____

Financial Assistance:
(Please indicate any specific interests of the Beneficiary that the trust may support in the future.)

- ☐ Spending money to use at his/her discretion (ONLY if no SSI or Medicaid benefits)
- ☐ Care management services to assist in handing bills and personal spending

Other:

_____

_____

_____

Funeral and Burial Planning:

It is necessary that CCT understands the Grantor's desires for the Beneficiary's funeral and burial plans. Funeral and burial expenses are not provided by public benefits.

Upon the death of the Beneficiary, the trust can no longer make disbursements. If the trust will be paying for these expenses, funeral arrangements need to be made and paid for prior to the death of the Beneficiary.

Have plans been made for beneficiary's funeral and burial arrangements? ☐ Yes ☐ No

Do you plan for the trust to pay these expenses (pre-need)? ☐ Yes ☐ No

If yes, who will be responsible for making final arrangements? Please provide name, address and telephone:

Name: _____ Relationship: _____

Address: _____

Phone Number: _____