# PLAN OF CT, INC. POOLED TRUST PERSONAL CARE PLAN

Beneficiary's Name: _____
*Last* *First* *M.I*

Address: _____
*Street Address* *Apartment/ Unit #*

_____
*City* *State* *Zip Code*

Date of Birth: _____ Social Security Number: _____

Martial Status: Single Married Widowed
*Please Circle One*

Spouse's Gross Income: $_____ Beneficiaries' Gross Income: $_____

Disability (e.g. Dementia, MS, etc.): _____

Proof of Disability Provided (Please Check One):

☐ Physician Statement

☐ SSD Payment Stub/Direct Deposit Slip

☐ Disability Determination Letter from Social Security or Colonial

☐ Page 3 of W300

Benefits: SSA SSDI SSI Medicaid Medicare Other: _____
*Please Circle All that Apply*

Home: Own Rent Section 8/ HUD Other:_____
*Please Circle One*

Name/Relationship of Person(s) Residing with the Beneficiary:

_____/_____
***Name*** ***Relationship***

_____/_____
***Name*** ***Relationship***

_____/_____
***Name*** ***Relationship***

Pre-Paid Funeral: Y N If yes, then please provide documentation.
*Please Circle One*

**Contact Person Information:**

Name: _____
*Last* *First* *M.I*

Relationship to Beneficiary: _____

Phone: _____ E-mail: _____

Address: _____
*Street Address* *Apartment/ Unit #*

_____
*City* *State* *Zip Code*

**Who would you like us to contact/ receive statements?**

Beneficiary or Other: _____/_____
***Name*** ***Relationship***

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**Spending Plan:**

Please list monthly expenses that you foresee the trust paying for (e.g. Rent, Gas, Electric, Cable, Taxes, Mortgage, Clothes, and Medical - not covered):

| Expense | Amount |
|---|---|
| *(e.g.) Electric* | *$120.00* |
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States Beneficiary has received Medicaid other than Connecticut:

_____

Signature of Person Filling out this Form:_____

Print Name: _____ Date:_____