NEW CLIENT INTAKE INFORMATION

DATE: _____

Representative (Attorney):

1. Name of Attorney:_____
2. Firm Name: _____
3. Address:_____

   _____

   _____
4. Phone: _____
5. Email: _____

Funding of Trust:

1. Initial Funding Amount: _____
2. Source of Funds (*sale of home, sale of investment, lawsuit settlement, inheritance, divorce, alimony, lottery winnings, etc.*): _____
3. Lump Sum? ❑ YES ❑ NO
   a. If no, how much is expected to be deposited at a time, and how often? _____

      _____

Grantor/Beneficiary: The Grantor/Beneficiary is:

1. Name: _____
2. Date of Birth: _____
3. Disability Diagnosis: _____
4. Current Residence: _____

   _____

   _____
5. Phone: _____
6. Email: _____
7. Social Security Number: _____
8. Marital Status? (*check one*)

   ❑MARRIED ❑DIVORCED ❑WIDOWED ❑NEVER MARRIED

Beneficiary's Representative: Conservator, Guardian, POA or Attorney-in-Fact:

1. Name: _____
2. Relationship to Beneficiary: _____
3. Address: _____

_____

_____

4. Phone:_____
5. Email: _____

Health Insurance and Coverage Information:

1. Is the beneficiary receiving Supplemental Security Income (SSI)? ❑ YES ❑ NO
2. Is the beneficiary receiving Social Security Disability Insurance (SSDI)? ❑ YES ❑ NO
3. Is the beneficiary receiving Medicaid Coverage? ❑ YES ❑ NO
4. If no, has an application been filed on behalf of the beneficiary? ❑ YES ❑ NO
    a. If so, when is Medicaid coverage expected? _____
5. Is the beneficiary a Veteran or the spouse a veteran? ❑ YES ❑ NO
    a. Is the beneficiary receiving Veteran's Aid & Attendance benefits? ❑ YES ❑ NO

- Please submit copies of the following:
    - **Photo ID, Social Security Award Letter (if applicable), Medicaid Award Letter (if applicable), Insurance cards**

Monthly Cash Needs Questionnaire:

NOTE: *To better service the beneficiary, the PACE Trust requests that you fill out the following information regarding the cash flow of the beneficiary's monthly income. This will assist staff when making distributions. PACE Trust staff may verify this information.*

1. Income: The net income received by the beneficiary each month, including source and amount.
    a. Money received from SSI: ……. $_____
    b. Money received from SSDI:…..…… $_____
    c. Money received from other:_____ $_____
    d. Money received from other:_____ $_____
    e. TOTAL MONTHLY INCOME…… $_____

2. Expenses: Please list any expenses you believe may be a qualified expenditure from the Trust.
    a. NURSING HOME: _____
        i. Room & Board …….. $_____
        ii. Private Room Differential ……. $_____

    b. ASSISTED LIVING FACILITY: _____

i. Room & Board …….. $_____

ii. Private Room Differential ……. $_____

c. MEDICATIONS: (expenses not covered by insurance)

i. Company: _____ $_____

ii. Company: _____ $_____

iii. Company: _____ $_____

d. NON-MEDICAL CAREGIVING:

i. Company: _____ $_____

e. ENTERTAINMENT:

i. Event: _____ $ _____

f. OTHER:

i. Expense: _____ $_____

ii. Expense: _____ $_____

iii. Expense: _____ $_____

Form Completed By: _____Date: _____

Printed Name: _____