Kara H. Daley
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THE CHERRY TREE
LAW FIRM

(541) 738-2445
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1717 NW Grant Avenue, Corvallis, Oregon 97330

SNT / DISABILITY TRUST INTAKE

Who is the trust for? Beneficiary information:
Name: _____
Address:_____City:_____State/Zip:_____
Date of Birth: _____ Age: _____
Social Security Number: _____
Medical/Disability Problems: _____
_____
(Attach medical records, if any.)

Where does the disabled person live *and/or* who has been taking care of him/her?
_____
_____

Is there a guardian, conservator, trustee, attorney (in the last three years), Agent appointed under a healthcare power of attorney, financial power of attorney or mental health nomination or other type of fiduciary appointed for or assisting the disabled person?
_____

How old was the beneficiary when the problems began?
_____

Source of the funds to be placed in the trust (i.e., inheritance, back SS, life insurance, IRA, custodial account, gifts from relatives, PI settlement, etc.):
_____

How did you become acquainted with the proposed beneficiary?
_____

Who is the Proposed Trustee:

Name/(Company if professional)_____Phone_____
Address:_____City:_____State/Zip:_____
Date of Birth: _____ Age: _____
Social Security Number: _____

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Background of trustee, and connection (if any) with family of beneficiary: _____
_____
_____
Hourly rates/ fee arrangement_____

Who could be listed as a successor trustee?
Name/(Company if professional)_____Phone_____
Address:_____City:_____State/Zip:_____
Date of Birth: _____ Age: _____
Social Security Number: _____
Background of trustee, and connection (if any) with family of beneficiary: _____
_____
_____
Hourly rates/ fee arrangement_____
_____

What public benefits, if any, is the beneficiary receiving? Please check below and attach verification of the benefit if available.

___ SS Retirement
___ SS disability–on parent's or beneficiary's own account?
___ SSI (Supplemental Security Income, less than $545/month)
___ Medicare
___ Medicaid–long-term care program? Mental health? Other?
___ Oregon Health Plan (Not LTC or disabled status Medicaid)
___ Long-term care services–nursing, foster, group homes
___ Mental Health Services (existing mental health lien? ___ Yes ___ No)
___ Oregon Department of Veterans Affairs benefits
___ Food Stamps (if yes, how much per month $_____?)

Other:_____
If applicable, please list the amount received monthly from each of these benefits. Please also specify if the pay out is in the disabled person's name or in another name (such as a parent):

_____
_____
_____

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What will the funds be used for?

_____
_____
_____
_____

What are the needs of the beneficiary?

_____
_____
_____

How will the funds be invested?

_____
_____
_____
_____

In what month will the funds be received? _____

Who will watch over the trustee to be sure the funds are safe?

_____
_____
_____

Are there any important deadlines that you are aware of? _____

Who will sign the petition? (Parent, grandparent, friend, guardian or conservator)

Name: _____Relationship: _____
Address:_____City:_____State/Zip:_____

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What are the addresses of the public agencies providing services? (By law, notice must be given to these agencies, documents are also sent to Salem Medicaid office if Medicaid is needed)
Name: _____
Address: _____
City: _____ State: _____
Zip: _____

Name: _____
Address: _____
City: _____ State: _____
Zip: _____

Name: _____
Address: _____
City: _____ State: _____
Zip: _____

Who will be named the secondary beneficiary? _____
("Second, pay any remainder, after the state's claim has been paid, to the descendants of the disabled person, or if none then to who?")

Who are the closest living relatives of the disabled person? Include: spouse/significant other, parents, adult children, siblings, or any person who is cohabiting with, living with, or is interested in the affairs or welfare of the disabled person. (These are the persons who, by law, must be given notice.)
Name: _____
Address:_____City:_____State/Zip:_____
Relationship: _____Age: __18 or older __Under 18 years

Name: _____
Address:_____City:_____State/Zip:_____
Relationship: _____Age: __18 or older __Under 18 years

Name: _____
Address:_____City:_____State/Zip:_____
Relationship: _____Age: __18 or older __Under 18 years
\\
Name: _____

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Address:_____________________________City:_________________State/Zip:_________________
Relationship: _______________________________Age: __18 or older __Under 18 years

Name: ____
Address:_____________________________City:_________________State/Zip:_________________
Relationship: _______________________________Age: __18 or older __Under 18 years

Name: ____
Address:_____________________________City:_________________State/Zip:_________________
Relationship: _______________________________Age: __18 or older __Under 18 years

Name: ____
Address:_____________________________City:_________________State/Zip:_________________
Relationship: _______________________________Age: __18 or older __Under 18 years

Name: ____
Address:_____________________________City:_________________State/Zip:_________________
Relationship: _______________________________Age: __18 or older __Under 18 years

Name: ____
Address:_____________________________City:_________________State/Zip:_________________
Relationship: _______________________________Age: __18 or older __Under 18 years

Name: ____
Address:_____________________________City:_________________State/Zip:_________________
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Name: ____

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Address:_____City:_____State/Zip:_____
Relationship: _____Age: __18 or older __Under 18 years

Are the disabled person's grandparent's still living? _____yes _____no
If yes, what contact does the disabled person have with his/her grandparents:
_____
_____

Names and Address of disabled person's case worker, physician, and other healthcare or social service workers involved with the disabled person if not listed above?
Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Relationship: _____

Names and Address of other parties who should be informed of this matter?
Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Relationship: _____

Are there any persons from who the disabled person needs protection?
_____
_____
_____

Has the disabled person ever received care from the Oregon State Hospital or other mental health services? ____ yes ____ no
If yes, are you aware of any public benefits lien? ____ yes ____ no

Please list all creditors of the disabled person:
Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Amount Owing/Monthly Payment: $_____/$_____
\\
Name: _____

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Address: _____
City: _____ State: _____
Zip: _____ Amount Owing/Monthly Payment: $_____/$_____

Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Amount Owing/Monthly Payment: $_____/$_____

Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Amount Owing/Monthly Payment: $_____/$_____

Name/phone of individual filling out this form: _____

Is there any other information you believe we should know?

_____
_____
_____

Thank you for taking the time to fill this form out.