1717 NW Grant Avenue, Corvallis, Oregon 97330

SNT / DISABILITY TRUST INTAKE

Who is the trust for? Beneficiary	information:	
Name:		
Address:	City:	State/Zip:
Social Security Number:		
Medical/Disability Problems:		
(Attach medical records, if any.)		
Where does the disabled person	live and/or who has beer	taking care of him/her?
——————————————————————————————————————	inancial power of attorne	ast three years), Agent appointed under by or mental health nomination or other erson?
How old was the beneficiary who	en the problems began?	
Source of the funds to be placed custodial account, gifts from rela		nce, back SS, life insurance, IRA,
How did you become acquainted	with the proposed benef	ficiary?
Who is the Proposed Trustee:		
Name/(Company if professional))	Phone
Address:	City:	State/Zip:
Date of Birth:		
Social Security Number:		

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Background of trustee, and connection	n (11 any) with famil	ly of beneficiary:
Hourly rates/ fee arrangement		
Who could be listed as a successor tru	istee?	
Name/(Company if professional)		Phone
Address:	City:	State/Zip:
Date of Birth:	Age:	
Social Security Number		
Background of trustee, and connection	n (if any) with famil	ly of beneficiary:
Hourly rates/ fee arrangement		
What public benefits, if any, is the berverification of the benefit if available. SS Retirement SS disability—on parent's or benefit if available. SSI (Supplemental Security Income Medicare Medicaid—long-term care program Oregon Health Plan (Not LTC or Long-term care services—nursing, Mental Health Services (existing and Oregon Department of Veterans And Food Stamps (if yes, how much pother:	ficiary's own accoume, less than \$545/rm? Mental health? Odisabled status Medisabled status Medisabled status home mental health lien?	ont? month) Other? dicaid) es Yes No)
of applicable, please list the amount respecify if the pay out is in the disabled	_	

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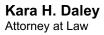
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What will the funds be used for?			
What are the needs of the benefic			
How will the funds be invested?			
In what month will the funds be a			
Who will watch over the trustee	to be sure the funds are s	afe?	
Are there any important deadline	s that you are aware of?		
Who will sign the petition? (Pare	ent, grandparent, friend, ş	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: City: State: Address: City: _____ State: ____ Name: _____ Address: ______ State: ______ State: _____ 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: City: State/Zip: Address: Relationship: ______Age: 18 or older Under 18 years Relationship: _____ Age: 18 or older Under 18 years Name: ____City:_____State/Zip:____ Address: Relationship: ______Age: __18 or older __Under 18 years





Address:	City:		Stat	e/Zip:	
Address:Relationship:		_Age: _	18 or older _	Under 18 years	
Name:					
Address:	City:		Stat	e/Zip:	
Address:Relationship:		_Age: _	18 or older _	_Under 18 years	
Name:					
Address:	City:		Stat	e/Zip:	
Name: Address: Relationship:		_Age: _	18 or older _	Under 18 years	
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Name:					



Address:	Address:	City:	Star	te/Zip:	
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:	Relationship:	Age: _	_18 or older _	Under 18 years	
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: 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: \$ /\$					
Names and Address of other parties who should be informed of this matter? Name:	service workers involved Name:	with the disabled person if not	listed above?		ocial
Names and Address of other parties who should be informed of this matter? Name:	City:	State			
Name:	Zip:	Relationship:			
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:Address:	State:			
services? yes no If yes, are you aware of any public benefits lien? yes no Please list all creditors of the disabled person: Name:	Are there any persons from	m who the disabled person need	ds protection?		
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Name:	services? yes n	0	_	ital or other mental	health
City: State: Zip: Amount Owing/Monthly Payment: \$/\$	Name:	the disabled person:			
Zip: Amount Owing/Monthly Payment: \$/\$		Q4 ·			
	City:	State:	Janthly Dazze		
		Amount Owing/N	ioniniy Payme	ent. \$/\$	



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Address:City:	State:	
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Name:		
Address:	G	
City:	State:	
Zip:	Amount Owing/Monthly Payment: \$	/\$_
Name:		
Address:	Ctoto	
City:	State:	
Zip:	Amount Owing/Monthly Payment: \$	/\$_
Name/phone of individ	ual filling out this form:	
	nation you believe we should know?	

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