

WESTERN NEW YORK COALITION TRUST APPLICATION

DEMOGRAPHICS

Name of applicant: _____
Home address: _____

City County State Zip

Telephone No.: _____

Social Security #: _____

Date of Birth: _____

Sex: Male: _____ Female: _____

Marital status: _____ Maiden Name: _____
(S = Single, M= Married, W= Widowed, D= Divorced)

Location of applicant: _____

Number of People in Household _____

RESPONSIBLE PERSONS or EMERGENCY CONTACT

Name _____ Relationship _____

Address _____
City County State Zip

Home phone _____ Work phone _____

E-Mail Address _____

Bank Power of Attorney Yes ___ No ___
Health Care Proxy Yes ___ No ___
Durable Power of Attorney Yes ___ No ___
Guardian Yes ___ No ___
Guardian proceeding pending Yes ___ No ___

MEDICAL INFORMATION

Nature and onset of your disability:

Do you use Medical equipment? Yes ___ No ___
If so what?

Do you have any medical bills or medically related expenses? Yes ___ No ___
Explain _____

Do you have home care? Yes ___ No ___ If yes, how often? _____

Do you have a case manager? Yes ___ No ___

What agencies are involved with your care?

MEDICARE #: _____

- Hospital coverage (Part A) _____
- Effective date _____
- Medical coverage (Part B) _____
- Effective date _____

MEDICAID CASE # _____

- Medicaid CIN # _____
- Effective date _____
- Medicaid pending? Yes ___ No ___
- Long-Term Care Insurance Yes ___ No ___

If yes, name of carrier: _____
What is the name of your waiver program? _____

INSURANCE COVERAGE

- Veteran Yes ___ No ___
- Spouse Veteran? Yes ___ No ___

Other Medical Insurance examples: (BC, BS, IHA, HCP, EPIC, No Fault)
(Please indicate any SNF coverage)

Company / Insurer	Certificate #	Prescription Card (Yes ___ No ___) If yes, #

INCOME INFORMATION

Indicate if received money from:

		<u>Amount</u>
• Wages, Salary (including overtime), Commissions, Self-employment	Yes ___ No ___	_____
• Unemployment Insurance Benefits	Yes ___ No ___	_____
• Supplemental Security Income (SSI) Benefits	Yes ___ No ___	_____
• Social Security Disability Benefits	Yes ___ No ___	_____
• Social Security Dependent Benefits	Yes ___ No ___	_____
• Social Security Survivor's Benefits	Yes ___ No ___	_____
• Social Security Retirement Benefits	Yes ___ No ___	_____
• Railroad Retirement Benefits	Yes ___ No ___	_____
• Retirement Benefits (Pensions)	Yes ___ No ___	_____
• Dividends/Interest from stocks, bonds, savings, etc.	Yes ___ No ___	_____
Specify: _____		
• Workers' Compensation	Yes ___ No ___	_____
• NYS Disability	Yes ___ No ___	_____
• Veteran's Pensions/Benefits/Aid and Attendance	Yes ___ No ___	_____
• Food Stamps	Yes ___ No ___	_____
• Education Grants or Loans	Yes ___ No ___	_____
Specify: _____		
• Contributions/Gifts (Received)	Yes ___ No ___	_____
• Child Support Payments	Yes ___ No ___	_____
• Alimony/Support (Received)	Yes ___ No ___	_____
• Private Disability Insurance:	Yes ___ No ___	_____
• Income from a Trust: (including income you are currently entitled to receive, or were entitled to receive in the past, that has not been distributed)	Yes ___ No ___	_____
• Training Allotments	Yes ___ No ___	_____
• Rental Income (Received)	Yes ___ No ___	_____
• Other		_____

RESOURCES INFORMATION

Indicate if **you**:

- Have cash on hand: Amount
Location: _____
- Have a checking account(s) Yes ___ No ___ _____
Location: _____
- Have a savings account(s) or certificate of deposit(s) Yes ___ No ___
Location: _____
- Have an irrevocable burial trust or fund Yes ___ No ___ _____
Specify: _____
- Are named the beneficiary of a trust Yes ___ No ___
- Expect to receive a trust fund, lawsuit, settlement, Inheritance or income from any other sources Yes ___ No ___
Specify: _____
- Have resources other than those listed above? Yes ___ No ___
Specify: _____

SHELTER EXPENSES

- What is your Landlord's name, _____
- Address, and phone number _____

- Do you have a rent, mortgage or other shelter expense? Yes ___ No ___ _____
Who? _____

Do you have the following expenses separate from your rent or shelter expense?

- Electricity Yes ___ No ___ _____
- Gas Yes ___ No ___ _____
- Other utilities (water, etc.) Yes ___ No ___ _____
- Telephone Yes ___ No ___ _____
- Air conditioning Yes ___ No ___ _____

- Do you live in public/ section 8 housing? Yes ___ No ___
Specify: _____

What money will be placed in the Trust and how often?
(Lump Sum) (Monthly Income/Spendedown) (Periodic Payments) (Court ordered)

How do you see the trust money being spent?

OTHER EXPENSES

Do you have, or would you like the trust to pay for:

- | | | | |
|-----------------------|---------|-------------------------|---------|
| • Cable | Y__ N__ | • Travel expenses | Y__ N__ |
| • Computer expenses | Y__ N__ | • Subscriptions | Y__ N__ |
| • Animal care | Y__ N__ | • Medical care | Y__ N__ |
| • Hobbies/collections | Y__ N__ | (companion/housekeeper) | |
| | | • Other Expenses | _____ |

ADDITIONAL COMMENTS:

Name of Interviewer: _____

Beneficiary, or Representative: _____
Signature Date

Beneficiary's Attorney _____
Signature Date

Please return completed Application to: Legal Services for the Elderly
438 Main St., Suite 1200
Buffalo, NY 14202
Attn. Pooled Trust