The Arc
Northern Virginia
Special Needs Trust
Serving DC, MD, & VA

Trust Department
The Foundation of The Arc of Northern Virginia
3060 Williams Drive, Suite 300
Fairfax, VA 22031
P: 703-208-1119

_____'s _____-Funded Special Needs Trust Plan

Statement of Purpose: This Trust Plan is to inform the Director of Trusts' decisions regarding expenditures on behalf of the Beneficiary. The Foundation's Trust Team is responsible for reviewing, approving and processing payments for goods and services needed by the Beneficiary. The content in the Trust Plan helps the Foundation's Trust team ensure that expenditures are aligned with the Beneficiary's needs by providing information about the individual's family, his/her disability, health issues, trusted representatives, benefits and income sources, and daily life. Although it is ultimately the Primary Representative's responsibility to arrange for and monitor the delivery of goods and services to the Beneficiary, the Foundation, as Manager of the Trust, ensures trust disbursements are fully documented, consistent with the Grantor's objectives for the Beneficiary, aligned with the Beneficiary's needs and previous spending patterns, and in keeping with government benefits eligibility requirements.

Beneficiary's Information:

Beneficiary (Full Name): _____
Beneficiary Address: _____
Beneficiary's Phone Number: _____
Beneficiary's Email Address: _____

Please check which benefits the Beneficiary currently receive:

☐ Food Stamps (SNAP)
☐ Medicaid
☐ Medicaid Auxiliary Grant
☐ Medicaid Waiver
  ☐ Community Living
  ☐ Family and Individual Supports
  ☐ Building Independence
  ☐ CCC+
  ☐ Other (specify): _____
☐ Medicare
☐ Social Security/Survivor Benefits
☐ Social Security Disability Insurance (SSDI)
☐ Supplemental Security Income (SSI)
☐ Subsidized Housing
☐ Private Health Insurance
☐ Other Income (specify):_____/month

Please list all states where the Beneficiary has received Medicaid benefits at any time, even if coverage was brief:
_____
_____
_____
_____
_____

Family History:

Beneficiary's Parent (Full Name): ______________________________
Parent's Address: ______________________________
Parent's Phone Number: ______________________________
Parent's Email Address: ______________________________
Marital Status: ☐ Married ☐ Divorced ☐ Widowed

Beneficiary's Parent (Full Name): ______________________________
Parent's Address: ______________________________
Parent's Phone Number: ______________________________
Parent's Email Address: ______________________________
Marital Status: ☐ Married ☐ Divorced ☐ Widowed

Does the beneficiary have any siblings? ☐ Yes ☐ No
*If yes, please provide the following information:

Sibling (Full Name): ______________________________
Date of Birth: ______________________________
Marital Status: ☐ Single, Never Married ☐ Married ☐ Divorced ☐ Widowed
If they have children, please share how many: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Sibling (Full Name): ______________________________
Date of Birth: ______________________________
Marital Status: ☐ Single, Never Married ☐ Married ☐ Divorced ☐ Widowed
If they have children, please share how many: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Sibling (Full Name): ______________________________
Date of Birth: ______________________________
Marital Status: ☐ Single, Never Married ☐ Married ☐ Divorced ☐ Widowed
If they have children, please share how many: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Sibling (Full Name): ______________________________
Date of Birth: ______________________________
Marital Status: ☐ Single, Never Married ☐ Married ☐ Divorced ☐ Widowed
If they have children, please share how many: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Sibling (Full Name): ______________________________
Date of Birth: ______________________________
Marital Status: ☐ Single, Never Married ☐ Married ☐ Divorced ☐ Widowed
If they have children, please share how many: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

Medical History:

Briefly describe the beneficiary's primary disability (diagnosis, when diagnosed, principal symptoms, coping strategies, therapies, etc.):

_____
_____
_____
_____
_____

Briefly describe the beneficiary's other disabilities (diagnosis, when diagnosed, principal symptoms, coping strategies, therapies, etc.):

_____
_____
_____
_____
_____

Provide us with a general summary of the beneficiary's developmental history, including milestones, transitions, and other areas that are pertinent to understanding the beneficiary's medical history:

_____
_____
_____
_____
_____

Does the beneficiary have a history of hospitalization? ☐ Yes ☐ No
*If yes, please describe and share when their most recent hospitalization occurred:

_____
_____
_____
_____

Current Status and Needs:

Residential:

_____
_____
_____
_____

Medical:

_____
_____
_____

_____
_____
_____

Current Supportive Services:

_____
_____
_____
_____
_____

Strengths:

_____
_____
_____
_____
_____

Areas of Life Requiring Support:

_____
_____
_____
_____
_____

Legal:

Are there any other legal authorities outside of what is shared on the Joinder Agreement (such as Health Proxy, Child Custody Agreement, etc.) that The Foundation of The Arc of Northern Virginia should know about? If so, please provide the information below:

Name (Full Name): _____
Address: _____
Phone Number: _____
Email Address: _____
Role of Party: _____
Date of Relevant Document: _____
☐ ***A copy of this document has been provide to The Foundation of The Arc of Northern Virginia***

Name (Full Name): _____
Address: _____
Phone Number: _____
Email Address: _____
Role of Party: _____
Date of Relevant Document: _____
☐ ***A copy of this document has been provide to The Foundation of The Arc of Northern Virginia***

For the Future:

Describe the Beneficiary's wants for their future:

_____
_____
_____
_____

Describe what the Beneficiary **does not** want for their future:

_____
_____
_____
_____

Describe the grantor's/grantors' and the beneficiary's wishes concerning their living arrangements for the future:

_____
_____
_____
_____

Describe the beneficiary's ability to manage money and make decisions surrounding financial matters:

_____
_____
_____
_____

Describe how the Grantor(s) prefer the funds in the trust be spent:

_____
_____
_____
_____
_____
_____
_____

In detail, describe what the trust funds should **NOT** pay for:

_____
_____
_____
_____
_____
_____
_____

Funeral Arrangements:

Please be aware that once a Beneficiary of a Self-Funded (First-Party) Special Needs Trust passes away, the trust is no longer permitted to disburse funds for any expenses, including funeral, burial, cremation, or related services. For this reason, we strongly encourage families to make pre-paid arrangements in advance if they wish to ensure these needs are covered. Please note that unlike Self-Funded Trusts, a Family-Funded (Third-Party) Trust may remain open after the Beneficiary's passing to pay for such expenses (see Section H.1 of the Family-Funded Joinder Agreement).

If arrangements already in place for the beneficiary's funeral, please describe below, including names and phone numbers for funeral homes, as well as any other parties involved. Alternatively, you can provide copies of arrangement contracts to be kept within the Beneficiary's file for reference in the future:

_____

_____

_____

_____

_____

If a pre-need arrangement is not already in place, please indicate your preferences in the table below to help guide future planning:

Type of Arrangement to Consider	Preference	
Irrevocable Burial Insurance	☐ Prefer	☐ Do Not Desire
Cemetery Plot	☐ Prefer	☐ Do Not Desire
Funeral Arrangements	☐ Prefer	☐ Do Not Desire
Cremation Arrangements	☐ Prefer	☐ Do Not Desire
Donate to Science	☐ Prefer	☐ Do Not Desire

NOTE: This is not a disbursement request to issue payment, nor is it a financial commitment for the trust to cover these costs. Only the identified Primary Representative(s) listed on the Joinder Agreement may authorize and take responsibility for disbursements related to pre-need arrangements.

If there are additional items would like to share relating to the Beneficiary that has not already been noted, please use this space to document other considerations or information:

_____

_____

_____

_____

To my knowledge, the information contained within this Trust Plan is current and accurate. If there are any changes surrounding the circumstances of the Beneficiary, I will contact The Foundation of The Arc of Northern Virginia to provide updates as they occur.

Signature: _____ Date: _____

Printed Name: _____

Trust Role: _____