717 ATLANTIC AVE
SUITE 8D
BOSTON, MA 02111

PHONE (888) 241-7534
FAX (617) 507-1085

INFO@CONTINENTAL-TRUST.COM

APPLICATION

Contact Information:

Claimant Information:

Full Name:____
Nickname: ____
Street Address ____
City ____________________________State__________Zip__________________
Home Phone No.: _______________ Fax No._______________________
Email Address:_________________ Cell No._______________________
Birth Date:_____________________ Social Security No. ________________
Gender: □ Male □ Female
Marital Status: Single/Married/ Divorced/Separated
Dependents: Yes/ No (If yes, please list) ________________________________
____
Work Status: Employed/ Unemployed/ Permanent Full Disability
Living Arrangements: Live Alone/ With Family/ Assisted Living/ Residentail Facility

Guardian/ Advocate Information

Name:____
Address:____
City______________________________State_________Zip_________________
Phone No.:________________________ Fax No.: ___________________
Email: ____________________________

Settlement Information:

Date of Settlement: ___________________________
Seed Trust: $_________________________
Annuity Provider: ______________________________ Annuity: $ _________ m/a/q/s

Broker

Name of Company____
Name of Contact ____
Telephone No. ________________________Fax No. _______________________
Email Address _______________________Cell No. _____________________

Other Contact

Name:____
Phone: _______________________ Email: _________________________

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Injury/Disability

Disabled Person Suffers from:

Nature of Injury/Disability:____

Date of Injury: ____

Eligibility Information

Workers Compensation: Yes / No
Private Insurance: Yes / No
If yes, name _____________________________________

Disabled Person Receives:

□ SSI and Medicaid- Amount of SSI: $________________________________
□ SSI Only- Amount of SSI: $____________________________________
□ SSDI and Medicare - Amount of SSDI: $____________________________________
□ Medicare- Medicare Coverage: Part A Part B Both
□ Medicaid Waiver
□ Section 8 Housing
□ Group Home
□ Facility
□ Veterans Disability Benefits
□ Other Public Benefits ____

If Disabled Person is not receiving any of these benefits, which, if any, have the filed for?

□ SSI: Date of Filing: ___________________
Has there been a determination of disability by the Social Security Administration?
□Yes □No
□Medicaid
□Medicaid Waiver
□SSDI Date of Filing: _____________________
□ Medicare: Is the Disabled person likely to be eligible for Medicare within 30 months
□Yes □No

Other Income, if applicable

Other Public Benefit Income (eg., food stamps): $____________
Pension Income (if any): $____________
Montly Income from Employment: $____________
Any other income: $____________

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Immediate Distributions

Home

Is a home purchase being considered?

□Yes □No

If yes, estimated amount of purchase? ____________________________________

Vehicle

Will a vehicle be purchased to meet the transportation needs of the disabled person?
Budget ($40,000 standard vehicle/$80,000 accessible)

□Yes □No

ABLE Account Lump Sum Funding / Annuity Funding

Paid Caregiving □Yes □No

Pro Rata Budget □Yes □No
If yes, please fill out "Current Monthly Obligations"

Truelink Budget: ________________

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CURRENT MONTHLY OBLIGATIONS

Home expenses (montly total)

Do you:

□Own
□Rent

Rent: $_______________
Mortage: $_______________
Property Tax: $_______________
Insurance: $_______________
Gas: $_______________
Electrical bill: $_______________
Water bill: $_______________
Sanitation bill: $_______________
Groceries: $_______________
Meals Outside the Home: $_______________
Phone bill: $_______________
Cell phone bill: $_______________
Cable bill: $_______________
Internet: $_______________
Other (specify): $_______________

Miscellaneous Expenses (monthly total):

Insurance

Life: $_______________
Health: $_______________
Disability: $_______________

Medical bills:

Doctor: $_______________
Medications: $_______________
Therapy: $_______________
Medical Suppy: $_______________

Clothing: $_______________
Entretainment: $_______________
Personal Expenses: $_______________
Child Support: $_______________
Income Tax payments: $_______________

Transportation (monthly total)

Do you own a car?

□Yes
□No

If yes,

Year _______________
Make _______________
Model_______________
Car Payment: $_______________
Insurance: $_______________
Monthly Gas: $_______________
Maintenance: $_______________

Current Obligations:

Please indicate even if past due or delinquent

Credit Cards:

Card type	Current Balance

Other Obligations (eg. Medical bills, student loans, past due taxes)

Type	Current Balance

The completion of this Questionnaire should not be deemed an aproval nor denial of any trust distribution request.