

**DAYONE RELIANCE, INC.
SELF SETTLED PAYBACK TRUST
CARE PLAN**

SOCIAL SECURITY NUMBER: _____ - _____ - _____

BENEFICIARY'S DATE OF BIRTH: (Mo., Day, Yr.)

PHONE NUMBER: (Area Code)

(____) _____

BENEFICIARY'S INFORMATION: (Please Print)

NAME: _____

ADDRESS :(Number, Street, City, State, Zip Code)

**BRIEF DESCRIPTION OF BENEFICIARY:
(DIAGNOSIS, FUNCTIONAL ABILITIES)**

CONTACT PERSON INFORMATION

NAME: _____

ADDRESS :(Number, Street, City, State, Zip Code)

TYPE OF TRUST

- Individual (d)(4)(A) Trust
- Pooled (d)(4)(C) Trust

CARE PLAN SUMMARY:

(SERVICES AND SUPPORTS TO BE PROVIDED TO THE INDIVIDUAL, IN PRIORITIZED ORDER)

CURRENT PROGRAMS AND SERVICES

(Please check one)

YES NO

____ Medicaid - Medicaid card number _____

____ Medicare - Medicare care number _____

____ Social Security Disability Income (SSDI) Amount per month \$ _____

____ Supplemental Security Income (SSI) Amount per month \$ _____

____ Income Benefit Award Letter (submitted) N/A _____

Other (please list) _____

CAREGIVER: (Complete if Applicable)

NAME: (Please Print) _____

ADDRESS: :(Number, Street, City, State, Zip Code)

PHONE NUMBER: (Area Code)

(____) _____

Caregiver Agreement submitted

(SS#): _____ - _____ - _____

FUNDING SOURCE:

INITIAL INVESTMENT:

\$ _____ . _____

DONOR / FAMILY MEMBER SIGNATURE: _____

DATE: _____

STAFF SIGNATURE: _____

DATE: _____

DAYONE RELIANCE, INCORPORATED

The following items are examples of allowable expenditures from a Pooled Trust. These items may include, but are not limited to:

- Clothing
- Moving expenses
- Automobile/Van
- Computer, software, maintenance service, internet service
- Clubs and club dues
- Home improvements, home alarm system/monitoring
- Legal fees/advocacy
- Therapy (Physical, Occupational and Speech) if not covered by Medicaid
- Funeral services/burial arrangements
- Vacations
- Linens, towels, bedding/household furnishings
- Haircuts/Salon services;
- Snow removal/Landscaping services
- Telephone service and equipment, including cell phones, pagers, etc.
- Physician specialists not covered by Medicaid

Guardians can contract services from outside vendors to provide additional support and/or assistance.

Guardianship expenses should be reimbursed.

Scheduled Disbursements

- 1. Item: _____
Amount: _____ Schedule of payments: _____
Name of Vendor/Payee: _____

Address of Vendor/Payee: _____
Account Number: _____
Phone Number: (Area Code) _____

- 2. Item: _____
Amount: _____ Schedule of payments: _____
Name of Vendor/Payee: _____

Address of Vendor/Payee: _____
Account Number: _____
Phone Number: (Area Code) _____

- 3. Item: _____
Amount: _____ Schedule of payments: _____
Name of Vendor/Payee: _____

Address of Vendor/Payee: _____
Account Number: _____
Phone Number: (Area Code) _____

- 4. Item: _____
Amount: _____ Schedule of payments: _____
Name of Vendor/Payee: _____

Address of Vendor/Payee: _____
Account Number: _____
Phone Number: (Area Code) _____

- 5. Item: _____
Amount: _____ Schedule of payments: _____
Name of Vendor/Payee: _____

Address of Vendor/Payee: _____
Account Number: _____
Phone Number: (Area Code) _____