

**INSTRUCTIONS FOR COMPLETING THE OPENING ACCOUNT FORM**

Once you complete the form, email it to [FamilyTrust@achieva.info](mailto:FamilyTrust@achieva.info) or forward it to:

ACHIEVA Family Trust  
**ATTN: Legal Department**  
711 Bingham Street  
Pittsburgh, PA 15203

**The information provided will remain confidential. Please fill out each section. Note that some sections may not be applicable to you and may remain blank. If you have any questions, please contact ACHIEVA Family Trust at 412-995-5000, ext. 565, or [FamilyTrust@achieva.info](mailto:FamilyTrust@achieva.info).**

**Part I:**

- Provide complete information about the **Beneficiary**.
- **If applicable**, mark the type of **Income** that the beneficiary receives.
- Identify the type of **Health Insurance** that the beneficiary has.
- List information about the beneficiary's **Mother** and **Father**. You **MUST** provide details of at least one parent if the beneficiary is a minor. The **SSN** can be helpful in the event the person may be eligible for SSD or benefits based on a parent's work history.
- **If applicable**, list the **Rep Payee**, **Power of Attorney**, or **Court-Appointed Guardian**. Please include copies of the relevant documents for our file.
- **If applicable**, identify the **Coordinator** and **Other Services** received by the beneficiary.

**Part II:**

- Identify the **Settlor**, the person or entity that is creating the trust. Please be sure to provide the Settlor's SSN. If the Settlor is deceased, please provide the decedent's SSN or Estate EIN. If the trust is funded from an education settlement, provide the School's information, to include its EIN. **These numbers are required in order for AFT to obtain an EIN for the trust.**
- **If applicable**, list the **Co-Trustee**. If the trust does not have one, please leave blank.
- **If known**, provide the name and address of the **Attorney** who assisted you.

**Part III:**

- Provide information about **Funding of Account**.
- List the name and address of the individual(s) who will receive **Quarterly Account Statements**. These may be sent to more than one individual. This section **must** have at least one person listed.
- This section **must** identify the name and address of **one** individual who will receive **Tax Information** for the beneficiary's personal income tax return. This can be a paid tax preparer, the beneficiary, or a family member. Transfers into the Trust are not tax deductible. The Trustee will issue appropriate Federal and State tax forms on a yearly basis. Beneficiaries should consult with their own tax advisor regarding their personal tax returns.
- **If applicable**, list any prepaid **Final Arrangements** for the Beneficiary.

Carefully read through the **Disclosure Statement**. Date and sign the document. Send the form to ACHIEVA Family Trust with other relevant documents, including Court Orders/Petitions, Wills, annuity contracts, etc. If the **Settlor** is a Court-appointed Guardian, he or she **must** sign for the Beneficiary.

**\*\*\* ACHIEVA Family Trust will send a Welcome Packet to the Settlor after the Trust is opened. The packet will include letters for the Beneficiary to send to the Social Security Administration and the Department of Human Services, as well as additional forms and information to help the Beneficiary. \*\*\***



**ACHIEVA FAMILY TRUST OPENING ACCOUNT INFORMATION FORM  
THIRD PARTY AND PAYBACK TRUSTS**

The following information is required to open a new trust account. Please complete applicable sections with as much detail as you can. If applicable, attach copies of relevant documents, including Court Orders/Petitions, Wills, annuity contracts, etc.

**PART I - INFORMATION ON BENEFICIARY**

**1. BENEFICIARY**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

County of Residence: \_\_\_\_\_

Are you a US citizen?      Yes              No      If no, where? \_\_\_\_\_

Lives:              Alone              With parents/guardian

Group Home (supply name): \_\_\_\_\_

Other: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Nature of Disability and Diagnosis: \_\_\_\_\_

\_\_\_\_\_



**Beneficiary (continued):**

Gender:                      Male              Female

Marital Status:              Single              Married              Divorced              Widowed

Race:                      White/European              Black/African              Asian

                                 Pacific Islander              Native American/Alaskan

Ethnicity:                      Non-Hispanic              Hispanic

**2. INCOME**

Provide information on all income received by the beneficiary. If known, please include identification numbers under which the benefits are received and amounts.

**SOCIAL SECURITY**

SSI Identification Number: \_\_\_\_\_ Monthly Amount: \_\_\_\_\_

SSDI Identification Number: \_\_\_\_\_ Monthly Amount: \_\_\_\_\_

Social Security Retirement

Identification Number: \_\_\_\_\_ Monthly Amount: \_\_\_\_\_

Social Security Survivors

Identification Number: \_\_\_\_\_ Monthly Amount: \_\_\_\_\_

**OTHER INCOME**

Veterans Administration: Monthly Amount: \_\_\_\_\_

Railroad Retirement: Monthly Amount: \_\_\_\_\_

Black Lung: Monthly Amount: \_\_\_\_\_

Public Assistance: Monthly Amount: \_\_\_\_\_

Wages: Monthly Amount: \_\_\_\_\_

Employer: \_\_\_\_\_

Pension: Former Employer: \_\_\_\_\_ Monthly Amount: \_\_\_\_\_

Other: Type of Income: \_\_\_\_\_ Amount: \_\_\_\_\_

Type of Income: \_\_\_\_\_ Amount: \_\_\_\_\_



**3. HEALTH INSURANCE**

Please indicate any health insurance coverage for the beneficiary and supply identification numbers, if known.

Medicare Identification Number: \_\_\_\_\_

Medical Assistance Identification Number: \_\_\_\_\_

Medicaid Waiver Identification Number: \_\_\_\_\_

Other: Name of Provider: \_\_\_\_\_

Policy No: \_\_\_\_\_

**4. MOTHER**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**5. FATHER**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**6. REP PAYEE / POWER OF ATTORNEY / COURT APPOINTED GUARDIAN**

**\*\*\* Please provide copy of Power of Attorney document or Court Order, if applicable. \*\*\***

Name: \_\_\_\_\_

Rep Payee                      Agent Under POA                      Court Appointed Guardian

Relationship to Beneficiary: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**7. COORDINATOR**

***Examples: Case Manager, Supports or Service Coordinator, etc.***

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**8. OTHER SERVICES**

***Examples: Waiver Services, OVR, etc.***

Type of Service: \_\_\_\_\_

Agency & Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**PART II - TRUST INFORMATION**

**1. GRANTOR/SETTLOR**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

SSN, Estate EIN, or School EIN: \_\_\_\_\_

***\*\*\* Required in order for ACHIEVA Family Trust to obtain an EIN for the trust. \*\*\****

Email address: \_\_\_\_\_

**2. CO-TRUSTEE**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

**3. ATTORNEY**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**PART III - INFORMATION REGARDING TRUST ADMINISTRATION**

**1. FUNDING OF ACCOUNT**

Amount to be Received: \_\_\_\_\_

Approximate Date of Funding: \_\_\_\_\_

Source of Funds: \_\_\_\_\_

*Examples: Settlement, Litigation Proceeds, Inheritance, etc.*

**\*\*\* If the trust will receive annuity payments, please provide a copy of the annuity contract as well as a name, address and telephone number for the contact person and payment frequency. \*\*\***

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**2. STATEMENT**

Please indicate the names and addresses of the individual(s) to receive quarterly statements. Quarterly statements can be sent to multiple individuals.

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**3. TAX INFORMATION**

List the name and address of the individual to receive tax information for filing personal tax returns on behalf of the beneficiary. Only **one** individual can receive tax information.

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**4. FINAL ARRANGEMENTS**

List any prepaid funeral or burial arrangements established for the beneficiary.

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**DISCLOSURE STATEMENT**

***I have asked ACHIEVA Family Trust to serve as trustee of funds.***

***I understand that those funds will be invested and I acknowledge:***

1. That ACHIEVA Family Trust may invest these funds with other funds, but account for them on an individual basis.
2. That these funds are not obligations or guaranteed by ACHIEVA Family Trust.
3. That these funds are not deposits insured by the Federal Deposit Insurance Corporation (FDIC), and are subject to investment risk, including possible loss of principal invested.
4. That ACHIEVA Family Trust adopts investment guidelines for trust funds and those investment guidelines can change at any time.
5. That the market values of investments do fluctuate, and upon liquidation, could be of value more or less than the market value of my original deposit into the trust account.
6. That income earned and retained in my trust account, or received in distributions from my trust account, will fluctuate over time.
7. That past investment performance either reviewed or considered by me is past performance only and not a guarantee of future results.
8. ***That I have been provided with a copy of the ACHIEVA Family Trust Fee Schedule.***  
I understand that fees charged by the trustee may reduce the principal amount of my trust account.
9. That trusts are taxable. ACHIEVA Family Trust will file fiduciary tax returns for its trusts and may charge my trust account for any taxes owed. ACHIEVA Family Trust will also send me tax information to include in my personal tax return.
10. That I am responsible for informing my State's Medicaid office about the trust.

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**(Settlor)**

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**(Beneficiary or Legal Representative)**