

CPT FIRST PARTY SPECIAL NEEDS TRUST APPLICATION
PRINT THIS FORM THEN GO ON TO STEP TWO AT WWW.SNTHelp.COM

TRUST BENEFICIARY				(Who the trust is being established for)	
First:		Last:			
Date of birth:	SSN:	Phone:			
Street address:					
City:	State:	ZIP code:			
Benefits:	Incapacitated (If yes court order required): <input type="checkbox"/> Yes <input type="checkbox"/> No			Minor: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Disability:			Email:		
Individual authorized to request funds from trust: <input type="checkbox"/> Self (If self you must provide successor advocate below) <input type="checkbox"/> Advocate					
ADVOCATE				(Only individual allowed to request funds from trust)	
<input type="checkbox"/> Advocate <input type="checkbox"/> Successor Advocate		Full name:			
Type: <input type="checkbox"/> POA <input type="checkbox"/> Guardian <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Friend <input type="checkbox"/> Family Member <input type="checkbox"/> Attorney					
Street address:				Phone:	
City:	State:	ZIP code:			
Email:			Relation to beneficiary:		
GRANTOR				(Who is establishing the trust, they must have authority)	
First		Last			
Established by: <input type="checkbox"/> Self <input type="checkbox"/> Guardian <input type="checkbox"/> Court <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent					
Court:				Court Supervised: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Judge:			Case Number:		
REFERRAL SOURCE				(*Required fields; so enrollment documents can be completed correctly)	
Name:		Firm/Company:			
Specialty:		Email trust documents to:			
Source of funding:					
Phone:		Estimated amount*:		Month to be funded*:	
REMAINDER BENEFICIARIES				(Social security number is required)	
Full name:		SSN:	Relation:		
Street:				Percent:	
City:	State:	ZIP code:			
Full name:		SSN:	Relation:		
Street:				Percent:	
City:	State:	ZIP code:			
Full name		SSN:	Relation:		
Street:				Percent:	
Full name:		SSN:	Relation:		
Street:				Percent:	
City:	State:	ZIP code:			
OTHER CASE ELEMENTS				(Please submit structured settlement or MSA documents when applicable)	
Ongoing funding from a Structured Settlement: <input type="checkbox"/> Yes <input type="checkbox"/> No			Medicare Set-aside to be held in trust: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>A separate payment stream to trustee for annual administration fees is required.</i>			<i>MSA's are administered by a third party vendor, additional fees apply.</i>		
Now go to Step 2: at www.snthelp.com and submit application online. We will send you trust documents within three business days. If you are unable to submit this online, please fax to 866-576-0460 or email to inbox@snthelp.com .					
If you need trust documents expedited please call 877-695-6444 Ext. 89.					