TRUST TRANSMITTAL FORM

All trusts established by the applicant/client, and all trusts in which the applicant/client is a beneficiary must be submitted to determine the effect of the trust on Medicaid eligibility. Please mail or fax a copy of the trust documents to:

Michelle Daniels
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203-1818
Fax: (303) 866-3552 **Phone: (303) 866-5410**

County:	
County Technician Name:	
Phone Number:	
Fax Number:	
Date:	

Name of Applicant:	
State ID or SSN:	
Type of Medical Assistance:	

Note: Income trusts are only valid for nursing facility, HCBS, or PACE.

INCOME TRUSTS

1) Please verify the applicant's income.
2) Please check the box which applies:

- ☐ Established by **applicant** (Consent Form attached)
- ☐ Established by **agent under a power of attorney** (Power of Attorney attached)
- ☐ Established by **guardian or conservator** (Court Order or Letters attached)
- ☐ Established by **court** (Court Signed Documents attached)

3) Please check the following on the trust document:

- ☐ **Space 2**: Does this state one of the following: applicant, agent under power of attorney, guardian, or conservator?
- ☐ **Space 6**: Is the trustee's address included?
- ☐ **Space 11**: Is the effective date correct? It can be no more than three months prior to the date of application, and the individual has to be resource eligible and medically eligible (determined by the ULTC-100.2) on that date.
- ☐ **Space 16**: Are the names and amounts of each source of income listed?

OTHER TRUSTS

The following documentation is submitted: _____

ADDITIONAL INFORMATION OR EXPLANATION:

_____

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