

DATE: \_\_\_\_\_

RE: **INCOME TRUSTS**

TO: District \_\_\_\_\_ Legal Counsel

THRU: Region \_\_\_\_\_ or Circuit \_\_\_\_\_ (ACCESS)

FROM: Unit \_\_\_\_\_, ES Name: \_\_\_\_\_

DATE: \_\_\_\_\_

After DLC review, return to ACCESS Region or Circuit Program Office.

1. Name of Individual:

\_\_\_\_\_

First

\_\_\_\_\_

M.I.

\_\_\_\_\_

Last

The written legal opinion of District Legal Counsel shown in this memorandum is subject to the "OBRA 93 Medicaid Trust Opinion Statement." This opinion is furnished solely to advise Department staff of legal issues related to certain trusts in connection with an individual's application for or receipt of benefits under the Medicaid Program in Florida. It may not be relied upon by any other person(s) without the prior written consent of the District Legal Counsel.

2. Name, address and telephone number of attorney or other individual who prepared the trust:

The trust was executed by:

☐ Individual

☐ Individual's spouse\*

☐ A person, including court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse. Specify and attach copy of documentation:

\_\_\_\_\_  
☐ Individual's legal representative. Specify and attach copy of documentation:

\_\_\_\_\_

\*No power of attorney is needed if executed by spouse.

**District Legal Counsel:**

2. ☐ Concur

☐ Do not concur

3. The trust is comprised of:

☐ The individual's income (and accumulated income) only

☐ Other (specify):

3. ☐ Concur

☐ Do not concur

4. Is the trust irrevocable?

☐ yes

☐ no

4. ☐ Concur

☐ Do not concur

5. Will the state receive all of the funds remaining in the trust at the time of the individual's death (up to the amount of Medicaid benefits paid on behalf of the individual)?

☐ yes

☐ no

5. ☐ Concur

☐ Do not concur

\_\_\_\_\_  
District Legal Counsel Signature

\_\_\_\_\_  
Date