TO SUBMIT THIS FORM

E-Mail: Trust@thearcoftexas.org

FAX: 512-454-4956

MAIL: 8001 Centre Park Drive, Suite 100 Austin, Texas 78754



CHANGE OF BENEFITS FORM					
Beneficiary:			Primary Rep (PR):		
Sub-Account Number:			PR Phone:		
Date:			PR Email:		
By completing this form, I am notifying the Master Pooled Trust of a change in benefits or living situation for the Beneficiary identified above. New or changes to benefits and/or living situations include:					
Check all benefits from the SOCIAL SECURITY ADMINISTRATION (SSA) that currently apply:					
	SSI \$ □ SSDI \$	_ □ SSA \$_	Dother (ty	/pe) _	\$
What date of the month are the benefits paid?					
Please check the types of MEDICAID the Beneficiary currently receives, if any:					
	HCS- Home and Community Based Services	☐ DBMD- Dea Disabilities	f Blind with Multiple		QMB- Qualified Medicare Beneficiary
	CLASS- Community Living Assistance & Support Services	□ Star Kids			SLMB- Service Limited Medicare Beneficiary
	STAR + Plus	☐ TxHmL- Te	exas Home Living		QI-1- Qualifying Individual Program
	YES	□ QDWI			STAR
	NORTH STAR	□ Other			
Living Situation (please only check one):					
	Rent # of occupants Mortgage # of occupants Own # of occupants Section 8 Voucher	 □ Group Home □ ICF-IID □ Nursing Home □ Assisted Living 			
The Beneficiary is no longer receiving (list benefits):					
Before sending in this form, visit https://www.yourtexasbenefits.com for the specific Medicaid benefits the Beneficiary is receiving. Visit https://www.ssa.gov/myaccount for the specific Social Security benefits the Beneficiary is receiving. *Documentation showing any change in benefits must be provided to the Master Pooled Trust*					
BENEFICIARY'S NAME (PLEASE PRINT):					
SIGNATURE of Primary Representative:DATE:					

Please allow **5-8 business days for processing**. Incomplete forms will be returned to the Primary Representative. VISIT OUR WEBSITE TO DOWNLOAD OR COMPLETE THIS FORM ONLINE: www.thearcoftexas.org/trust-forms

Updated 5/1/2022 FORM D