TRUST TRANSMITTAL FORM

All trusts established by the applicant/client or their spouse and all trusts in which the applicant/client or their spouse is a beneficiary must be submitted to determine the effect of the trust on Medicaid eligibility. Please email, fax or mail a copy of the trust document and supporting materials, along with this Trust Transmittal Form to:

Address: **Colorado Department of Health Care Policy and Financing**
Attn: Trust Unit
1570 Grant Street, Denver, CO 80203-1818
Email: **Medicaid.Trusts@hcpf.state.co.us**
Fax: **(303) 866-3552** **Total pages: _____**

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

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

Note: Income trusts are only valid for nursing facility, HCBS, or PACE (PLEASE SPECIFY)

1. INCOME TRUSTS:

A. Indicate which type of Settlor is establishing the trust (Only *one* box should be marked):

- ☐ **Applicant** (The Consent Form **must** be included.)
- ☐ **Agent under a power of attorney** (Documentation of the POA **must** be included.)
- ☐ **Guardian or conservator** (A Copy of Court Order or Letters **must** be included.)
- ☐ C**ourt** (**Copy of Court Signed Documents required**)

B. Please make sure the trust document has been completed including:

- ☐ **Spaces 6 and 7**: Enter complete addresses for both the primary and alternate trustee.
- ☐ **Space 11**: An effective date **must** be entered and can be no more than three months prior to the date of application.
- ☐ **Schedule A**: Is each source and amount of income listed?

2. OTHER TRUSTS:

Type of trust and/or documentation: _____

3. ADDITIONAL INFORMATION: