QUALIFIED INCOME TRUST
APPROVED FORMAT DEVIATION FORM

Section 1 – To be completed by County DFCS Date sent: _____

Client's Name (Beneficiary of trust): _____

Client ID number: _____ AU number: _____

DFCS County Office: _____ Phone #: _____

Medicaid Worker's Name: _____ CL #: _____

Medicaid Worker's Address: _____

Describe how the trust deviates from one of the DCH approved QIT formats: (Also list the page number where the deviation is located in the trust.)

Section 2 – To be completed by DCH Legal Services

____ Trust Approved ___ Trust NOT Approved

Date Returned to DFCS: _____

Comments:_____

Signature: _____

09/04