

APPLICATION FOR TRUSTEESHIP

Form Approved
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PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED APPLICATION TO:

Director, Defense Finance and Accounting Service -
Cleveland Center (Code G),
P.O. Box 998006, Room 2829
Cleveland, OH 44199-8006

PRIVACY ACT STATEMENT

AUTHORITY: 37 USC Chapter 11; EO 9397.

PRINCIPAL PURPOSE: To apply for appointment of trusteeship for a mentally incompetent member of the uniformed services.

ROUTINE USE(S): Information may be released to the Internal Revenue Service for tax administration; General Accounting Office for auditing; Department of Veterans Affairs for pay entitlements; Social Security Administration for pay entitlements; American Red Cross for locator service; military aid societies for family assistance; and Office of Personnel Management for pay entitlements.

DISCLOSURE: Voluntary; however, if the information is not provided, an appointment of a trustee cannot be made.

SECTION I - INFORMATION ABOUT THE SERVICE MEMBER

1. NAME (Last, First, Middle Initial)	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SERVICE	4. RANK
5. CURRENT ADDRESS (Street, Apartment Number, City, State, and ZIP Code)			6. TELEPHONE (Include Area Code)
7. STATUS OF MEMBER (X one) (If member is not at home, give name and address of facility)			
<input type="checkbox"/> HOSPITALIZED/ NURSING HOME	<input type="checkbox"/> HOME	<input type="checkbox"/> OTHER (Specify)	

SECTION II - APPLICATION FOR TRUSTEESHIP

8. I, _____, request that I be designated Trustee to receive and administer payments of active duty or retired pay on behalf of the above cited member who is unable to manage his/her own financial affairs. I certify that I am 21 years of age, or older, and that I have reasonable cause in maintaining funds for the welfare and benefit of the cited member.

My relationship to the cited member is:

☐ LAWFUL SPOUSE ☐ CHILD ☐ OTHER (Specify)
☐ HEAD OF INSTITUTION OF CONFINEMENT ☐ PARENT ☐ ADOPTED CHILD

9. MEMBER'S IMMEDIATE FAMILY (Attach continuation sheet if necessary)

a. NAME (Last, First, Middle Initial)	b. DATE OF BIRTH (YYYYMMDD)	c. ADDRESS (Street, City, State, ZIP Code)	d. RELATIONSHIP

10. CONDITIONS

Regulations established pursuant to appointing a Trustee to receive pay on behalf of mentally incompetent members who are incapable of handling their own financial affairs, provided a guardian or other legal representative has not been appointed by a court of competent jurisdiction, require the Trustee named to:

- Provide a suitable bond, paid from amounts due the member, when payments can reasonably be expected to exceed \$1,000.
- Post a new bond equal to the Trustee bank account balance, plus the projected accrual for 12 months following the date of such balance, if requested to do so by the Director of the appropriate Defense Finance and Accounting Service Center.
- Deposit all funds in a special bank account and draw checks in the name of the Trustee or persons to whom payments are made.

THE TRUSTEE WILL NOT DRAW CHECKS TO "CASH" OR PAYABLE TO THE MEMBER.

- Serve the best interests of the member without fee of any kind. Trustee may not obligate funds for attorney fees or similar charges.
- Obtain prior approval before expending funds on other than ordinary items needed for member's maintenance, care and comfort.
- Submit financial reports on a recurring basis, as may be directed, using the form furnished. Support all expenditures with cancelled checks or receipts and bank statements showing balances.

Trusteeship is subject to termination upon death of the member; death or disability of Trustee; appointment of a committee, guardian or fiduciary by a competent court; failure of Trustee to render reports; improper use of DoD funds; medical determination of member's return to competency; or discretion of the Director of the appropriate DFAS Center.

11. APPLICANT'S SIGNATURE	12. ADDRESS (Street, City, State, ZIP Code)	13. TELEPHONE (Include Area Code)	14. DATE (YYYYMMDD)
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SECTION III - DESIGNATION OF TRUSTEE (Do not write in this area.)

_____ is hereby appointed as Trustee to receive and disburse funds on behalf of the mentally incompetent member of the United States military named above. This designation is contingent on compliance with the instruction given by DFAS-CL/DE personnel.

15. DESIGNATOR NAME (Last, First, Middle Initial)	16. TITLE	17. SIGNATURE	18. DATE (YYYYMMDD)
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