SPECIAL NEEDS TRUST QUESTIONNAIRE

|  |  |  |  |
| --- | --- | --- | --- |
| PERSONAL DATA (PERSON IN NEED): |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | DOB |       |
| Address: |       |  | County: |       |
| Day Phone: |       |  | Eve. Phone: |        |  | Email: |       |

United States Citizen? Yes [ ]  No [ ]

|  |  |  |  |
| --- | --- | --- | --- |
| Father’s Name: |       | DOB |       |
| Address: |       |  | County: |       |
| Day Phone: |       |  | Eve. Phone: |        |  | Email: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Mother’s Name: |       | DOB |       |
| Address: |       |  | County: |       |
| Day Phone: |       |  | Eve. Phone: |        |  | Email: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Spouse’s Name: |       | DOB |       |
| Address: |       |  | County: |       |
| Day Phone: |       |  | Eve. Phone: |        |  | Email: |       |

|  |
| --- |
| CHILDREN OR SIBLINGS (If no children): |
| Name: |       | Age: |       | Address: |       | Phone: |        |
| Name: |       | Age: |       | Address: |       | Phone: |       |
| Name: |       | Age: |       | Address: |       | Phone: |       |
| Name: |       | Age: |       | Address: |       | Phone: |       |

|  |  |
| --- | --- |
| Anyone else residing with person in need? | **Yes [ ]  No [ ]**  |
| If yes, please explain: |       |

|  |
| --- |
| MEDICAL/DISABILITY |

What is the nature of the injury/disability and the individual’s current and future needs related to their disability?

|  |
| --- |
|       |

Is anyone else in the family disabled? Yes [ ]  No [ ]

|  |  |
| --- | --- |
| If yes, please explain: |       |

Is anyone at risk for becoming seriously ill or disabled because of a medical condition or family history? Yes [ ]  No [ ]

|  |  |
| --- | --- |
| If yes, please explain: |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Doctor’s Name: |  | Address: |  | Phone # |
|        |  |       |  |       |

Has anyone in the family recently entered a hospital or skilled nursing facility? Yes [ ]  No [ ]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of facility: |       |  | Date of admission: |       |
| Date of discharge: |       |  | Diagnosis: |       |

## HEALTH INSURANCE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | YOU |  | FAMILY MEMBER |
| Medicare |  | [ ]  |  | [ ]  |
| Insurance from Employer |  | [ ]  |  | [ ]  |
| Medicare Supplement |  | [ ]  |  | [ ]  |
| Long Term Care Insurance |  | [ ]  |  | [ ]  |
| Other:       |  | [ ]  |  | [ ]  |
|       |  | [ ]  |  | [ ]  |
|       |  | [ ]  |  | [ ]  |

## GOVERNMENT BENEFITS

### Are you, your parents, spouse or children receiving any of the following benefits?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROGRAM |  | YOU |  | FAMILY MEMBER |
| SSI |  | [ ]  |  | [ ]  |
| SSDI |  | [ ]  |  | [ ]  |
| TANF |  | [ ]  |  | [ ]  |
| Food Stamps |  | [ ]  |  | [ ]  |
| Subsidized Housing |  | [ ]  |  | [ ]  |
| Other:       |  | [ ]  |  | [ ]  |
|       |  | [ ]  |  | [ ]  |
|       |  | [ ]  |  | [ ]  |

## FINANCIAL

Settlement of Claim:

|  |  |  |  |
| --- | --- | --- | --- |
| Has a settlement been finalized? | **Yes [ ]  No [ ]**  | If so, what was the amount? |        |

How is the settlement structured?

|  |
| --- |
|       |
| Does anyone have income producing assets? | **Yes [ ]  No [ ]**  |  |

*(Bank accounts, Brokerage Accounts, Stocks, Corporate of U.S. Bonds, other)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Description of Asset |  | Value |  | Account No. |  | In Whose Name? |
|       |  | $       |  |       |  |       |
|       |  | $       |  |       |  |       |
|       |  | $       |  |       |  |       |
|       |  | $       |  |       |  |       |
| TOTAL |  | $       |  |  |  |  |

Have you or other family members made any transfer or gifts of $13,000 or more during the past three years: **Yes [ ]  No [ ]**

## REAL ESTATE

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Description of Property |  | Purchase Date |  | Purchase Price |  | Value |  | In Whose Name |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |  |       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Monthly Income: |  | Yours |  | Your Spouse |  | Joint |
| Social Security |  |       |  |       |  |       |
| Employment |  |       |  |       |  |       |
| Pension from:       |  |       |  |       |  |       |
| IRAs, Annuities, etc       |  |       |  |       |  |       |
| Rents:       |  |       |  |       |  |       |
| Business Interests:       |  |       |  |       |  |       |
| Other:       |  |       |  |       |  |       |
| TOTAL |  |       |  |       |  |       |

## LIFE INSURANCE

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Whose Life? |  | Beneficiary |  | Face Value |  |  Cash Value |  | Policy No. |
|       |  |       |  |       |  |       |  |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ins. Company: |       |  | Contact Name: |       |
| Address: |       | Contact Phone #: |       |

Do you have IRAs, Vested Pension Plan, Annuities, or Other Assets that would pass on your death to a particular designated beneficiary? **Yes [ ]  No [ ]**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Description |  | Value |  | Designated Beneficiary |
|       |  |       |  |       |
|       |  |       |  |       |

Do you or any family members expect an inheritance? Yes [ ]  No [ ]

Are you or a family member that beneficiary of any trust? Yes [ ]  No [ ]

## LIABILITIES: (liens, mortgages, notes to banks, notes to others, loans on insurance, other)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Description** |  | **Balance Due** |  | **Monthly Payment** |  | **Maturity Date** |
|       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |
|       |  |       |  |       |  |       |

Is there an outstanding Medicare or Medicaid lien? Yes [ ]  No [ ]

|  |  |  |
| --- | --- | --- |
| Description |  | Balance Due |
|       |  |       |
|       |  |       |
|       |  |       |

## LIFE INSURANCE (Autos, RVs, Boats, Antiques, Heirlooms, Jewelry, Collectibles, etc)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Description of Property |  | Value |  | In Whose Name? |
|       |  |       |  |       |
|       |  |       |  |       |
|       |  |       |  |       |
|       |  |       |  |       |

## MONTHLY EXPENSES (Average)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HOUSING |  |  | AUTOMOBILE |  |
| Rent/Mortgage |       |  | Loan Payments |       |
| Property Taxes |       |  | Insurance |       |
| Insurance |       |  | Gas/Oil |       |
| Telephone |       |  | Maintenance/Repairs |       |
| Cable TV |       |  |  |  |
| Electric/Gas |       |  | DEBTS |  |
| Maintenance/Repairs |       |  | Credit Cards |       |
| Other |       |  | Other |       |
| Other |       |  | Other |       |

###

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MEDICAL |  |  | CLOTHING |  |
| Insurance |       |  | Purchases |       |
| Doctor/Dentist |       |  | Dry Cleaners |       |
| Prescriptions |       |  |  |  |
| Home Health Care |       |  | ENTERTAINMENT/RECREATION |
|  |  |  | Vacation |       |
| MISCELLANEOUS |  |  | Eating Out |       |
| Gifts |       |  | Club Dues |       |
| Food |       |  | Other |       |
| Other |       |  | Other |       |
| TOTAL | $       |  | TOTAL | $       |

## LEGAL/ESTATE PLANNING

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date Made |  | Location of Original |
| Last Will and Testament |       |  |       |
| Durable Power of Attorney |       |  |       |
| Living Will/Health Care Proxy |       |  |       |
| Living Trust |       |  |       |

Please bring copies of the following documents with you to your meeting with the attorney: (*where applicable*)

* Litigation Complaint
* Guardianship Order
* Proposed or Final Settlement and Release
* Will, Codicil, Trust Agreements
* Real Estate Deeds, Appraisals
* Admission Agreements to hospitals and health facilities
* Divorce Decrees, Prenuptial Agreements, Adoption Papers
* Guardianship documents
* Living Will, Health Care Declaration or Power of Attorney, Durable Powers of Attorney
* Regarding anyone who will have a part in your planning (*trustees, personal representatives, beneficiaries, helpers, and/or advisors*)
	+ Full names
	+ Addresses
	+ Telephone number(s)
	+ Email address(es)
* Retirement plans, including any forms designating beneficiaries