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