

# McAndrews Law Offices, P.C.



Attorneys At Law

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## SPECIAL NEEDS TRUST QUESTIONNAIRE

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

### Beneficiary Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Nature of Disability of Beneficiary - If available, please provide a document which describes the nature and extent of the disability.

\_\_\_\_\_

Is the Beneficiary Adjudicated Incapacitated? \_\_\_\_\_  
If yes, please include the Guardianship Court Order.

Is the Beneficiary married? \_\_\_\_\_

If yes, please list name of spouse: \_\_\_\_\_

Does the Beneficiary have any children? \_\_\_\_\_

If yes, please list names and ages: \_\_\_\_\_

\_\_\_\_\_

Does the disabled person have assets in his or her own name in excess of \$2000.00? \_\_\_\_\_

If yes, please list type of asset and approximate value.  
\_\_\_\_\_

Is the disabled beneficiary a beneficiary of a trust established by any person? \_\_\_\_\_ If yes:

1. Is the disabled person a current, remainder or contingent beneficiary? \_\_\_\_\_

2. Please provide a copy of all such trusts

3. Are there other relatives or persons who are likely to include the disabled person as a beneficiary under their own estate plans?  
\_\_\_\_\_

Public Benefits received by Beneficiary (please provide documentation):

☐ Supplemental Security Income (SSI) - Amount: \_\_\_\_\_

☐ Medical Assistance (MA)/Medicaid - Provider: \_\_\_\_\_

☐ State Supplementary Payment (SSP) - Amount: \_\_\_\_\_

☐ Mental Health/Intellectual Disability Benefits (MD/ID): \_\_\_\_\_

☐ Waiver Program - Type: \_\_\_\_\_

☐ Social Security Disability Income (SSDI) - Amount: \_\_\_\_\_

☐ Medicare: \_\_\_\_\_

☐ Section 8 Housing: \_\_\_\_\_

☐ Supplemental Nutrition Assistance Program (SNAP)/Food Stamps-  
Amount: \_\_\_\_\_

☐ Other: \_\_\_\_\_

Is Beneficiary employed: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Approximate Monthly Salary: \_\_\_\_\_

Name of proposed Settlor (must be competent beneficiary, parent, grandparent, guardian, or via court order)

\_\_\_\_\_  
Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

Name(s) and Address(es) of Contingent Beneficiary(s) to receive Trust monies at death of beneficiary and after payment of Medicaid liens.

\_\_\_\_\_  
\_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

Source of monies for trust (e.g., settlement of litigation, inheritance, gift(s), Social Security back payments):

\_\_\_\_\_

Amount \_\_\_\_\_

Are any assets that would fund the SNT held in an IRA, 401k, 403b, other tax deferred asset, or in an annuity or structured settlement? If so, please list:

How much is held in the account: \_\_\_\_\_

Account owner: \_\_\_\_\_

Account beneficiary: \_\_\_\_\_

Where the account is held: \_\_\_\_\_

Please attach an account statement.

If Settlement of Litigation:

Is a structured settlement involved: \_\_\_\_\_

Caption of Litigation: \_\_\_\_\_

Attorney Name: \_\_\_\_\_

Proposed Trustee(s) (individual or corporate fiduciary - if corporate: name of contact person):

\_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Social Security Number of Trustee: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

Proposed Alternate Trustee(s) (if any): \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

Referred by: \_\_\_\_\_

Please provide a short description of your current situation and the problem with which you would like our help:

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