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Attorneys At Law

SPECIAL NEEDS TRUST QUESTIONNAIRE

Your Name:_____ Date: _____

Address: _____

Phone Number: _____

Email Address: _____

Relationship to Beneficiary with a disability: _____

Name of Beneficiary with a disability: _____

Address: _____

Phone Number: _____

Email Address: _____

Date of Birth of Beneficiary: _____

Social Security Number of Beneficiary: _____

Nature of Disability of Beneficiary – If available, please provide a document which describes the nature and extent of the disability and state whether any guardian has ever been appointed for the disabled beneficiary.

_____

Has the beneficiary been adjudicated incapacitated? _____

If yes, please include a copy of the Court Order.

Name of proposed settlor (must be 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) who might receive any remaining Trust monies upon the death of the disabled beneficiary after payment of future Medicaid liens accrued during operation of the Trust.

_____

_____

_____

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

Amount (including payment schedule if structured settlement is involved):

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: _____

Caption of any Underlying Litigation (if any):

_____

Type(s) and Amount(s) of Public Benefits received by beneficiary (please provide documentation evidencing benefits selected below):

☐ Supplemental Security Income (SSI) – Amount: _____

☐ Medical Assistance (MA)/Medicaid – Provider: _____

☐ State Supplementary Payment (SSP) – Amount: _____

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

☐ Waiver Program: _____

☐ Social Security Disability Income (SSDI) – Amount: _____

☐ Medicare: _____

☐ Section 8 Housing: _____

☐ Supplemental Nutrition Assistance Program (SNAP)/Food Stamps–Amount:____

☐ Other: _____

If Beneficiary is employed:

Name of Employer: _____

Approximate Monthly Salary: _____

Referred by: _____

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

_____

_____

_____

_____

_____