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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:____

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 is the account 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: ____

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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