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Date: _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

Instructions | Please print clearly

Please complete this form to the best of your ability so that we may provide the most informative consultation. This information is confidential.

If someone other than the person seeking services is completing this form, please provide:

Name: _____

Relationship to the person seeking services: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

INFORMATION ABOUT THE PERSON SEEKING SERVICES

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

Marital Status: _____

Employer: _____ Retirement Date: _____

Employer Address: _____

City, State, Zip: _____

FAMILY INFORMATION

Parents
If deceased, only name and date of death are needed

Mother's Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

FAMILY INFORMATION

Parents
If deceased, only name and date of death are needed

Father's Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Children
If deceased, only name and date of death are needed

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

Children
If deceased, only name and date of death are needed

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

REAL ESTATE

Home Address: _____

Name(s) on Deed: _____

Date of Purchase: _____ Purchase Price: $ _____

Mortgage Balance: $ _____ Market Value: $ _____

Other Real Estate Property Address: _____

Name(s) on Deed: _____

Date of Purchase: _____ Purchase Price: $ _____

Mortgage Balance: $ _____ Market Value: $ _____

VEHICLES

Make/Year: _____

Name(s) on Title: _____

Loan Balance: $ _____ Market Value: $ _____

Make/Year: _____

Name(s) on title: _____

Loan Balance: $ _____ Market Value: $ _____

ACCOUNTS & INVESTMENTS

Savings Account(s)

Bank: _____ Account #: _____

Name(s) on Account: _____

Average Balance: $ _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Average Balance: $ _____

ACCOUNTS & INVESTMENTS

Checking Account(s)

Bank: _____ Account #: _____

Name(s) on Account: _____

Average Balance: $ _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Average Balance: $ _____

Bank Certificate of Deposit

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: $ _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: $ _____

Mutual Funds

Name of Fund: _____ Account #: _____

Name(s) on Account: _____

Value: $ _____

Name of Fund: _____ Account #: _____

Name(s) on Account: _____

Value: $ _____

Name of Fund: _____ Account #: _____

Name(s) on Account: _____

Value: $ _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

ACCOUNTS & INVESTMENTS

Stocks & Bonds

Name of Brokerage Co.: _____ Certif #: _____

Purchase Date: _____ # of Shares: _____ Value: $ _____

Name of Brokerage Co.: _____ Certif #: _____

Purchase Date: _____ # of Shares: _____ Value: $ _____

Name of Brokerage Co.: _____ Certif #: _____

Purchase Date: _____ # of Shares: _____ Value: $ _____

IRAs, Keoughs, 401(k) Plans, Annuities, etc.

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: $ _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: $ _____

PREPAID FUNERAL

Plot Location: _____ Value: $ _____

Headstone Location: _____ Value: $ _____

OTHER ASSETS

Description: _____ Value: $ _____

Description: _____ Value: $ _____

Is the person the beneficiary of any Trust? Yes ☐ No ☐

If yes, please attach a photocopy of a signed version if available or provide any details you can regarding the terms and conditions, identity of the current trustee, amount of principal, etc. _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

INSURANCE

Life

Company: _____ Policy #: _____ Whole ☐ Term ☐

Policy Owner: _____ Insured: _____

Beneficiary: _____ Contingent Beneficiary: _____

Face Value: $ _____ Cash Surrender Value: $ _____

Supplemental
Include
Long-Term
Care Policies

Company: _____ Policy #: _____

Policy Owner: _____ Beneficiary: _____

Value: $ _____ Duration: _____

Health

Check all that apply:

☐ Medicare Medicare #: _____

☐ Medicaid DCN # _____

☐ Medicare Supplemental Insurance

Company: _____ Policy #: _____

Monthly premium: $ _____

How is the premium paid? _____

☐ Other Insurance

Company: _____ Policy #: _____

Monthly premium: $ _____

How is the premium paid? _____

INCOME/ PUBLIC BENEFITS

Employment: _____ $ _____/month

Social Security Retirement: _____ $ _____/month

Social Security Disability: _____ $ _____/month

Supplemental Security Income: _____ $ _____/month

Veteran's Benefits: _____ $ _____/month

Private Pension: _____ $ _____/month

Annuity: _____ $ _____/month

Medicaid: _____ $ _____/month

Food Stamps: _____ $ _____/month

Subsidized Housing: _____ $ _____/month

Other Income:: _____ $ _____/month

Is the person eligible for Medicare? Yes ☐ No ☐ If yes, when? _____

Is the person and/or any other household family member applied for government assistance/benefits? Yes ☐ No ☐

If yes, please name the family member, the type of assistance, and date of application (i.e., Medicaid, Veterans' Benefits, SSI, SSDI, etc.): _____

_____

_____

Is it likely the person will require any public benefits assistance in the future? Yes ☐ No ☐

MONTHLY EXPENSES

Rent: _____ $ _____ /month

Mortgage: _____ $ _____ /month

Real estate taxes: _____ $ _____ /month

Homeowners/renters insurance: _____ $ _____ /month

Utilities (water, sewer, gas, telephone, and trash): _____ $ _____ /month

Other household expenses: _____ $ _____ /month

$ _____ /month

Debts (other than housing or vehicles): _____ $ _____ /month

_____ $ _____ /month

_____ $ _____ /month

Nursing home fees: _____ $ _____ /month

Medical insurance: _____ $ _____ /month

Prescription medications: _____ $ _____ /month

Other medical expenses: _____ $ _____ /month

Other miscellaneous expenses: _____ $ _____ /month

_____ $ _____ /month

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

DOCUMENT INFORMATION

The following questions concern information needed to prepare documents. The person may have already made choices regarding the information requested. Please indicate if the person is undecided and we will discuss this at our consultation.

If a Trust is prepared, who shall serve as the Trustee?

First Choice: _____

Second Choice: _____

Name of person to receive remaining assets from the person's trust at death? _____

Relationship to the person: _____

Address: _____

City, State, Zip: _____

Amount/Percentage: _____

Name of person to receive remaining assets from the person's trust at death? _____

Relationship to the person: _____

Address: _____

City, State, Zip: _____

Amount/Percentage: _____

SPECIAL NEEDS TRUST QUESTIONNAIRE
CONFIDENTIAL INFORMATION

DOCUMENT INFORMATION

Does the person currently have a Power of Attorney for finances? Yes ☐ No ☐

If so, who is the Attorney-in-Fact? _____

If a Power of Attorney is needed, name of proposed Attorney-in-Fact: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of Successor Attorney-in-Fact: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

ATTACHMENTS

Please provide the copies of the following documents, if applicable:

I. Guardianship Order and/or Documents

2. Divorce Decrees, Prenuptial Agreements, Adoption Papers

3. Retirement Plans, including any forms designating beneficiaries

4. Health Insurance Policy and Summary of Benefits

5. Copy of Medicaid Card or other Public Assistance Identification Card(s)