Special Needs Lawyers, PA

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Special Needs Trusts | Elder Law | Long Term Care Planning | Medicaid | Probate | Wills & Trusts
Incapacity Planning | Guardianship | Developmental Disabilities | Veteran's Benefits

CONFIDENTIAL
SPECIAL NEEDS QUESTIONNAIRE

THIS INFORMATION IS EXTREMELY IMPORTANT. PLEASE PRINT AND BE AS COMPLETE AS POSSIBLE.
Please use the last page to write additional information if necessary.

Date_____

Personal data of the **PARENT/ INTERESTED PERSON(S)**:

Name _____

Home address _____

City _____ State_____ Zip _____

Telephone number_____

E-mail address _____

Social Security #_____

Date of birth_____

U.S. citizen: Yes_____ No _____

Relationship to Beneficiary: _____

Personal data of the **PARENT/ INTERESTED PERSON(S)**: (if any):

Name _____

Home address _____

City _____ State_____ Zip _____

Telephone number_____

E-mail address _____

Social Security #_____

Date of birth_____

U.S. citizen: Yes_____ No _____

Relationship to Beneficiary: _____

Personal data of the **Individual with a Disability**:

Individual's name _____

Home address _____

City _____ State _____ Zip _____

Telephone number _____

E-mail address _____

Social Security # _____

Date of birth _____

U.S. citizen: Yes _____ No _____

Name of **Individual's Spouse**, if applicable _____

Please identify the **Individual's** Disabilities, Diagnoses, or Reason for a Special Needs Trust: _____

_____

_____

_____

_____

Has the **Individual** been determined to be disabled by Social Security? _____

Government Assistance

Please indicate all forms of government assistance that the Individual receives **or is applying for** and the dollar amounts received per month, where applicable.

Social Security …….	Yes _____	No _____	$_____
Supplemental Security Income (SSI) …….	Yes _____	No _____	$_____
Social Security Disability Insurance (SSDI)……..	Yes _____	No _____	$ _____
Medicaid Institutional Care Program (Nursing Home Care)…..	Yes _____	No _____	
Medically Needy Program …….	Yes _____	No _____	
MEDS-AD…….....	Yes _____	No _____	
Medi-Kids……..	Yes _____	No _____	

Protected Medicaid…….. Yes _____ No _____

Home or Community Based Medicaid Waiver Programs… Yes _____ No _____

Optional State Supplementation (OSS)…….. Yes _____ No _____ $_____

Home Care for the Elderly and Disabled (HCE/DA)……. Yes _____ No _____

Food Stamps…… Yes _____ No _____ $_____

Veteran's Benefits (Aid and Attendance) Yes _____ No _____ $ _____

Other Programs _____

ADVANCE DIRECTIVES

Please identify what, if any, Advance Directives the **Individual has executed** or if the **Individual** has a Court Appointed Guardian and who the empowered individuals are.

Durable Power of Attorney: Yes _____ No _____

Declaration of Health Care Surrogate/ Health Care Power of Attorney Yes _____ No _____

Living Will: Yes _____ No _____

Declaration of Pre-need Guardian Yes _____ No _____

Guardian Appointed? Yes _____ No _____

What Type of Guardianship _____
(Plenary or Limited; Person and/or Property or Guardian Advocacy)

Please identify the agents under the Advance Directives or the Guardian:

1. _____
2. _____
3. _____

<u>OTHERS INTERESTED IN THE Individual's WELFARE</u>

PLEASE PRINT ALL NAMES AS THEY WOULD APPEAR ON LEGAL DOCUMENTS.

Name: ______________________________ Date of Birth: ________________________
Address: ______________________ City: _______________ State: _____ Zip: _______
Relationship: _________________________ Telephone Number: __________________
Spouse's Name: ______________________ Date of Birth: ________________________

Name: ______________________________ Date of Birth: ________________________
Address: ______________________ City: _______________ State: _____ Zip: _______
Relationship: _________________________ Telephone Number: __________________
Spouse's Name: ______________________ Date of Birth: ________________________

Name: ______________________________ Date of Birth: ________________________
Address: ______________________ City: _______________ State: _____ Zip: _______
Relationship: _________________________ Telephone Number: __________________
Spouse's Name: ______________________ Date of Birth: ________________________

Name: ______________________________ Date of Birth: ________________________
Address: ______________________ City: _______________ State: _____ Zip: _______
Relationship: _________________________ Telephone Number: __________________
Spouse's Name: ______________________ Date of Birth: ________________________

Name: ______________________________ Date of Birth: ________________________
Address: ______________________ City: _______________ State: _____ Zip: _______
Relationship: _________________________ Telephone Number: __________________
Spouse's Name: ______________________ Date of Birth: ________________________

Name: ______________________________ Date of Birth: ________________________
Address: ______________________ City: _______________ State: _____ Zip: _______
Relationship: _________________________ Telephone Number: __________________
Spouse's Name: ______________________ Date of Birth: ________________________

NOTE: THIS INFORMATION IS COMPLETELY CONFIDENTIAL AND IS FOR USE IN SPECIAL NEEDS PLANNING ONLY. IT WILL NOT BE USED FOR ADVERTISING OR MARKETING PURPOSES, AND THESE PERSONS WILL NOT, UNDER ANY CIRCUMSTANCES, BE CONTACTED FOR ANY PURPOSE WITHOUT YOUR CONSENT.

DOCUMENTS TO PROVIDE WITH QUESTIONNAIRE

COPY OF THE BENEFICIARY'S CURRENT WILL, TRUST, TRUST AMENDMENTS, DURABLE POWER OF ATTORNEY, HEALTH CARE SURROGATE, LIVING WILL, AND ANY OTHER ESTATE PLANNING DOCUMENTS.

COPIES OF ANY DOCUMENTS THAT NAME THE BENEFICIARY AS A PERSON RECEIVING THE ASSET OR HAVING AN INTEREST IN THE ASSET AT A FUTURE TIME, SUCH AS BENEFICIARY DESIGNATION, PAY ON DEATH DESIGNATION ETC.

ADDITIONAL INFORMATION

LIST ANY OTHER IMPORTANT INFORMATION OR WRITE ANY QUESTIONS YOU HAVE HERE.