Special Needs Lawyers, PA

901 Chestnut Street, Suite C
Clearwater, Florida 33756

Phone: (727) 443-7898
Fax: (727) 631-0970

SpecialNeedsLawyers.com
Info@specialneedslawyers.com

Travis D. Finchum, Esq.
Board Certified in Elder Law

Linda R. Chamberlain, Esq.
Board Certified in Elder Law

Charles F. Robinson, Esq.
Board Certified in Elder Law

Kole J. Long, Esq.
Elder Law Attorney

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. ____

OTHERS INTERESTED IN THE Individual's WELFARE

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.

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____