



# ANDERSON ELDER LAW

206 Old State Rd, Media, PA 19063 T: 610-566-4700 F: 610-566-4702

## SELF-SETTLED SPECIAL NEEDS TRUSTS QUESTIONNAIRE

Date: \_\_\_\_\_ File Number: \_\_\_\_\_

**This form is extremely important. Your accuracy and completeness in responding will help me represent you.**

### A. DISABLED PERSON

Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Medicaid No.: \_\_\_\_\_ Medicare Claim No.: \_\_\_\_\_

Gender:  Male  Female

#### 1. Disabled Person Suffers from:

- |   |  |
|---|--|
| <input type="checkbox"/> Asperger Syndrome                | <input type="checkbox"/> Fragile X Syndrome            |
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Mental Illness                |
| <input type="checkbox"/> Autism                           | <input type="checkbox"/> Mental Retardation            |
| <input type="checkbox"/> Bi-Polar Disorder                | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Blindness                        | <input type="checkbox"/> Paraplegia                    |
| <input type="checkbox"/> Borderline Personality Disorder  | <input type="checkbox"/> Quadriplegia                  |
| <input type="checkbox"/> Brain Injury                     | <input type="checkbox"/> Rett Syndrome                 |
| <input type="checkbox"/> Cerebral Palsy                   | <input type="checkbox"/> Schizoaffective Disorder      |
| <input type="checkbox"/> Deafness                         | <input type="checkbox"/> Schizophrenia                 |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Spina Bifida                  |
| <input type="checkbox"/> Developmentally Delayed          | <input type="checkbox"/> Tourettes Syndrome            |
| <input type="checkbox"/> Dissociative Disorder            | <input type="checkbox"/> Traumatic Brain Injury        |
| <input type="checkbox"/> Down Syndrome                    | <input type="checkbox"/> Other: _____                  |
| <input type="checkbox"/> Epilepsy                         |  |

2. Prognosis: \_\_\_\_\_

#### 3. Disabled Person Receives:

- SSI and Medicaid – Amount of SSI: \$
- SSD and Medicare
- SSI Only – Amount of SSI \$
- Medicaid Waiver Section 8 Housing
- DDD
- Group Home
- Psychiatric Institutionalization
- Veterans Disability Benefits
- Other Public Benefits: \_\_\_\_\_



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#### 4. If disabled person is not receiving any public benefits, which, if any, have they filed for?

SSI Date of Filing: \_\_\_\_\_

Has there been a determination of disability by the Social Security Administration?

Yes       No    If yes, please provide copy of determination letter

SSD Date of Filing: \_\_\_\_\_

Has there been a determination of disability by the Social Security Administration?

Yes       No    If yes, please provide copy of determination letter

Medicaid

Medicare: Is the disabled person likely to be eligible for Medicare within 30 months of the settlement?

Yes     No

Medicaid Waiver

Section 8 Housing

DDD

Group Home \_\_\_\_\_

Psychiatric Institution \_\_\_\_\_

Veterans Disability Benefits

Other Public Benefits: \_\_\_\_\_

#### B. MISCELLANEOUS DATA

##### 1. Living Arrangement

Disabled person is living:     At home     In an institution

If in an Institution: \_\_\_\_\_

Name of Institution: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Name of Contact Person at Institution: \_\_\_\_\_



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## 2. Citizenship

Disabled person is:  U.S. Citizen  Qualified Alien  Don't Know

## 3. Competency

Disabled Person is:  Competent Adult  Incompetent Adult  
 Minor expected to be competent at majority  
 Minor expected to be incompetent at majority

## 4. Social Security

Address of Social Security office with which disabled person has contact:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Name of Claims Representative: \_\_\_\_\_

## 5. Disabled Person's Parents

What is the marital status of disabled person's parents if disabled person is living with either of them?

Married  Single  Widowed  Divorced

**A. Name of Father:** \_\_\_\_\_

Street (if different from disabled person) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

U.S. Citizen?  Yes  No

If no, explain under what legal right the father is in this country.

\_\_\_\_\_  
\_\_\_\_\_

If father will sign trust as grantor, it will be signed in:

State: \_\_\_\_\_ County: \_\_\_\_\_



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**B. Name of Mother:** \_\_\_\_\_

Street (if different from disabled person) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

U.S. Citizen?  Yes  No

If no, explain under what legal right the mother is in this country.

\_\_\_\_\_

If mother will sign trust as grantor, it will be signed in:

State: \_\_\_\_\_ County: \_\_\_\_\_

## 6. Guardianship

Is the disabled person the subject of a guardianship?  Yes  No

If yes, please provide the following:

Name of Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Name of Co-Guardian (if applicable) \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Please attach court orders, guardianship letters and related pleadings.

If the disabled person is incompetent and is not subject to a guardianship, is a guardianship required?

Yes  No

**NOTE:** If yes, complete guardianship intake forms.



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## 7. Disabled Person's Family

Disabled person is:  Married  Single

If married, Name of Disabled Person's Spouse: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Age of Child: \_\_\_\_\_

Is this child a stepchild?  Yes  No

Name of Child: \_\_\_\_\_ Age of Child: \_\_\_\_\_

Is this child a stepchild?  Yes  No

Name of Child: \_\_\_\_\_ Age of Child: \_\_\_\_\_

Is this child a stepchild?  Yes  No

## C. ATTORNEY

Personal Injury Attorney: \_\_\_\_\_

Name of Law Firm: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Defense Attorney: \_\_\_\_\_

Name of Law Firm: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

## D. STRUCTURED SETTLEMENT BROKER

Name of Attorney: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_



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## E. TRUST INFORMATION

### 1. Establishment of Trust

Who will establish the Trust? \_\_\_\_\_

Name of Judge: \_\_\_\_\_

Order of \_\_\_\_\_ Court,

Name of County: \_\_\_\_\_

Docket No.: \_\_\_\_\_

Party Role:     Defendant                       Executor of Estate:

Name of Decedent: \_\_\_\_\_

Division:         \_\_\_\_\_

Orphans Court

Guardian(s) [name(s) provided above]

Name of Father: \_\_\_\_\_  
(address provided above)

Name of Mother: \_\_\_\_\_  
(address provided above)

Name of Grandparent: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

### 2. Trustee

Who will serve as Trustee?

**Name of Initial Trustee:** \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Contact Person (if corporate trustee): \_\_\_\_\_

Trustee will sign the acceptance of the Trust document in:        State \_\_\_\_\_

County \_\_\_\_\_

If the trustee is an individual, is he/she bondable?     Yes     No



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Name of Successor Trustee: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Contact Person (if corporate trustee): \_\_\_\_\_

### 3. Age Requirement

If any contingent beneficiary of the trust is relatively young, what will the age requirement be for distribution?

Trustee Retains Distribution until age:  30  35  Other: \_\_\_\_\_

Withdrawal Rights:  1/3 at Age \_\_\_\_\_, 1/3 at Age \_\_\_\_\_, 1/3 at Age \_\_\_\_\_

1/2 at Age \_\_\_\_\_, 1/2 at Age \_\_\_\_\_

All at Age \_\_\_\_\_

If no remaining descendants:  In accordance with Intestate Laws

To \_\_\_\_\_

### 4. Real Estate

Will the Trust own any real estate?  Yes  No

If yes, provide the following:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Single Family Dwelling

Townhouse

Condominium

Apartment

## F. ESTATE PLANNING DOCUMENTS

### 1. Disabled Person

If the disabled person is competent, he/she has a:

Will

Health Care Power of Attorney

Living Will

Power of Attorney

Banking Power of Attorney

Would you like intake forms sent to you so that these documents can be prepared/updated?

Yes  No



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## 2. Disabled Person's Family

Do family members have:

- Wills
- Health Care Powers of Attorney
- Financial Powers of Attorney
- Third-Party Special Needs Trust

Would you like intake forms sent to you so that these documents can be prepared?

- Yes  No

## G. EXCEPTIONS FROM CONFIDENTIALITY

Select all that apply:

- Attorney
- Trustee
- Other Family Members: \_\_\_\_\_

## H. CLIENT

Who is the Client?

- Disabled Person
- Father of Disabled Person
- Mother of Disabled Person
- Grandparent of Disabled Person
- Guardian of Disabled Person
- PI or Family Law Attorney
- Trustee

## I. PLEADINGS

If a Complaint has been filed, please attach a copy of the Complaint. If a settlement has been reached, please attach a copy of the Settlement Agreement.

## J. IMMEDIATE DISTRIBUTIONS

### 1. Home

Is a home purchase being considered?  Yes  No

If yes, estimated amount of purchase: \$ \_\_\_\_\_

**NOTE:** It is better to have this purchased via a lump sum rather than a structure. We need to discuss whether the home should be purchased by the family, the trust, or the disabled person individually.

### 2. Vehicle

Will a vehicle be purchased to meet the transportation needs of the disabled person?

Yes  No If yes, estimated amount of purchase: \$ \_\_\_\_\_

**NOTE:** This should be purchased from a lump sum rather than a structure. We should discuss the best way to purchase this before the settlement is finalized, if possible.



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## K. REFERRAL

Who referred you to this office?

Full Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Referral is:  PI Attorney  Structured Settlement Broker  
 Trust Company  Other \_\_\_\_\_

## L. CERTIFICATION:

**I HAVE REVIEWED THE INFORMATION CONTAINED IN THIS QUESTIONNAIRE AND VERIFY THAT IT IS COMPLETE, ACCURATE, AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Signature of Person Preparing Form

\_\_\_\_\_  
Date