

SELF-SETTLED SPECIAL NEEDS TRUSTS QUESTIONNAIRE

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

File Name: _____

Date: _____ File Number: _____

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
-
-
- SSD and Medicare
-
-
- SSI Only
-
-
- DDD
-
-
- Group Home
-
-
- Psychiatric Institutionalization
-
-
- Other Public Benefits: _____

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 Medicaid SSD Date of Filing: _____ MedicareIs 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 _____ 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: _____

2. CitizenshipDisabled 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: _____

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.

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. PERSONAL INJURY ATTORNEY

Name of Attorney: _____

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.: _____

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: _____ Probate Equity 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**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

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. 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 _____

H. LEGAL SERVICES TO BE PERFORMED BY ANDERSON ELDER LAW, LLC**1. Basic Services**

- Determine whether a Self-Settled Special Needs Trust is appropriate
- Draft Special Needs Trust
- File for Social Security Administration approval of the Special Needs Trust
- File for State Medicaid Agency approval of the Special Needs Trust
- File Trust with Housing Authority and discuss with Director
- Assist in identifying an appropriate trustee
- Conference with trustee(s) to explain trust administration
- Counsel disabled person, family members, and trustee(s) on establishment of Special Needs

2. Trust, funding, administration, and distributions

- Counsel disabled person, family members, and trustee(s), as appropriate, with respect to public benefit programs that the Disabled Person is receiving or may be entitled to receive
 - Obtain taxpayer identification number
 - Advise appropriate parties with respect to trust funding
 - Assist grantor and trustee in funding the trust
 - Letter to trustee(s) of the special needs trust outlining the trustee's duties with respect to establishing the trust, paying taxes and compensation, general duties of trustee, review of the SSI/Medicaid program (if appropriate), distributions from the trust, and reporting guidelines to public agencies administering public-benefit programs
 - Other _____
-

3. Advice Respecting Settlement

- Advise the law firm representing the Disabled Person concerning aspects of the settlement
- Advise the law firm representing the Disabled Person with respect to public-benefits requirements pertaining to award or settlement
- Advise as to allocation between spouses or between parent and child
- Advise as to whether a special needs trust is required
- Advise as to whether and how much to structure
- Advise as to what items should be paid for directly from settlement and what should be paid from the trust

4. Litigation Services

- Draft Complaint to create a special needs trust
- Draft Order to Show Cause to create a special needs trust
- Draft Brief regarding court's authority to create a special needs trust
- Notice to interested party referencing creation of a special needs trust
- Attend court hearing to obtain approval of special needs trust
- Preparation and filing of Order authorizing establishment of special needs trust

5. Third-Party Claims and Liens

- Advise state Medicaid agency of settlement
- Negotiate and compromise state Medicaid agency lien as appropriate
- Prepare written release from state Medicaid agency
- Letter to state Medicaid agency enclosing payoff check and obtain written release
- Advise Medicare of settlement and request a payoff of Medicare claim
- Negotiate and compromise Medicare claim as appropriate
- Letter to Medicare enclosing payoff check
- Advise third-party insurance companies of settlement and request a payoff
- Negotiate and compromise third-party claims as appropriate
- Letter to third-party claimants enclosing payoff check

I. EXCEPTIONS FROM CONFIDENTIALITY

Select all that apply:

 Attorney Trustee Other Family Members: _____**J. 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

K. 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.

L. 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.

M. 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