

## Special Needs Trust Planning Questionnaire

As often is the case, attorneys view creation of a special needs trust as a panacea. Placing all of a disabled individual's assets into an irrevocable trust, however, is much more complicated than filling in the blanks on the trust documents and turning over a funding check. Proper planning requires that the attorney look at the unique aspects of each disabled person's case to determine how and if the trust serves their current and future goals. A special needs trust is not, on its own, a care plan. It is one component, one tool, of a well-crafted care plan that is designed to maximize the benefits available to the disabled person, as well as maximize their independence. Please complete this form so we can determine how best to maximize benefits.

Name of Prospective Trust Beneficiary: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Relationship to beneficiary: \_\_\_\_\_

### Guardianship Status (check one):

- Guardianship (Please attach court orders, guardianship letters, and related pleadings.)
- No Guardianship

### Source of the Trust Funds:

*Who is settling the Trust?*

- The Trust Beneficiary (e.g. a lawsuit settlement, inheritance, etc.)
- A Third Party (e.g., relative gifting money to trust for a person with disabilities)

### OBRA Qualification:

Over 65?     Yes     No  
Age \_\_\_\_\_ Date of birth \_\_\_\_\_

### Beneficiary Profile:

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

City, State, Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_

Medicaid No. \_\_\_\_\_

Medicare Claim No. \_\_\_\_\_

Gender     M     F     Non-Binary

Married?     Yes     No    Spouse's Name \_\_\_\_\_

Children?     Yes     No    Children's names/ages: \_\_\_\_\_

Siblings names/Ages \_\_\_\_\_



Beneficiary's social network (what is the level of involvement? How are they assisting?)

Family: \_\_\_\_\_  
\_\_\_\_\_

Friends: \_\_\_\_\_  
\_\_\_\_\_

Volunteers: \_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

Are custodial care services currently in place?     Yes     No

If Yes, please describe:

Skill level of service provider: \_\_\_\_\_

Functions being performed: \_\_\_\_\_  
\_\_\_\_\_

Days and hours: \_\_\_\_\_  
\_\_\_\_\_

What gaps exist as it relates to needs/wants that are currently being unmet?

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

Is the beneficiary receiving any ancillary programming? (e.g., day programs)

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

What does the beneficiary like to do? Are there any impediments to them doing activities?

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

How stable is the beneficiary's care plan?

Highly Stable – unlikely to change in the next ten (10) years

Stable – unlikely to change in the next two (2) years

Unstable – likely to change within the next two (2) years

Unsure/do not have enough information to assess stability of care plan (why? What information is missing? \_\_\_\_\_)

**Public Benefits/Insurance:**

Is the beneficiary currently receiving the following?

➤ Medicaid:       Yes    No

    If No, who will be applying for Medicaid on behalf of the beneficiary?  
\_\_\_\_\_

➤ Medicare:       Yes    No

➤ Medicare Supplemental Insurance:       Yes    No

➤ SSI:       Yes    No

    If Yes, how much per month: \_\_\_\_\_

➤ SSDI:       Yes       No

    If Yes, how much per month: \_\_\_\_\_

➤ Veteran's Benefits       Yes    No

    If Yes, how much per month: \_\_\_\_\_

**Financial:**

How much does the beneficiary own:

Checking/Savings: \_\_\_\_\_

Retirement: \_\_\_\_\_

CDs: \_\_\_\_\_

Other cash account/valuable property: \_\_\_\_\_

Does the beneficiary have life insurance? \_\_\_\_\_

Does the beneficiary have stocks or bonds? \_\_\_\_\_

    If Yes, approx. value: \_\_\_\_\_

    Cost basis (if available): \_\_\_\_\_

Does the beneficiary have annuity? \_\_\_\_\_

If Yes, please indicate type:

Self-directed (e.g., variable annuity)

Right to payment/monthly or episodic disbursements (e.g., structured settlement)

Other income: \_\_\_\_\_

ABLE Eligibility:

Was the blind or disabled before before age 26?:  Yes  No

Was the beneficiary receiving Supplemental Security Income (SSI) based on blindness or disability that began before age 26?:  Yes  No

Does the beneficiary have existing debt (e.g., credit cards, loans)? Yes No

If Yes, describe type and how much: \_\_\_\_\_

Does the beneficiary own real estate? Yes No

If Yes, please answer the following questions:

How is the real estate titled? \_\_\_\_\_

Are capital improvements/expenditures expected? \_\_\_\_\_ Describe: \_\_\_\_\_

Does the beneficiary own an automobile(s)? Yes No

If Yes, please answer the following questions:

Who drives the vehicle(s): \_\_\_\_\_

Are the vehicle(s) and all the drivers insured? \_\_\_\_\_

If No, are you thinking of purchasing a vehicle? \_\_\_\_\_

SSDI

Is/was Beneficiary employed?  Yes  No

If yes, for how long? \_\_\_\_\_

How much does Beneficiary currently receive in SSDI? \_\_\_\_\_

What type of employment, if any, could beneficiary perform now?

Would Beneficiary's salary likely be less than \$1,130/month?  Yes  No

Budget:

Current budget/total annual expenditures:

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Proposed budget:

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Will there be any disbursements that negatively affect SSI?

Yes     No

If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Will the trust be paying for private health insurance?

Yes     No

**Legal Issues:**

Is there an existing Power of Attorney?

Yes     No

If Yes, please indicate below:

Power of Attorney for Property

Name and relationship: \_\_\_\_\_

Power of Attorney for Health Care

Name and relationship: \_\_\_\_\_

Does the beneficiary have legal counsel?

Yes     No

If Yes, who: \_\_\_\_\_

Upon the death of the beneficiary, who should any remaining trust funds go to?

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**Other considerations:**

Will the beneficiary understand the complexity of the limitations placed on disbursements by the trustee per federal and state law?

Yes     No

Will the fiduciary (the Trustee) understand the complexity of the limitations of disbursements?

Yes     No

Has the beneficiary been required to file individual tax returns for the past two (2) years?

Yes     No

### CERTIFICATION

The undersigned hereby represents to Bielski Chapman Ltd. that the information contained in this questionnaire (including the attached schedules) is accurate and complete, and that the undersigned understands that the law firm will rely on this information. If the information contained herein is inaccurate or incomplete, the recommendations made by Bielski Chapman Ltd. may not be appropriate.

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Signature of client or representative

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Date