JULIAN GRAY ASSOCIATES

ELDER LAW ♦ ESTATE & DISABILITY PLANNING

AVOID MISTAKES. PROTECT ASSETS.

SPECIAL NEEDS
PLANNING QUESTIONNAIRE

(PLEASE COMPLETE THIS PACKET IN INK)

This information packet must be returned to us at least three days prior to your meeting (this will ensure we have enough time to understand the specifics of your situation before our meeting). If you need assistance completing the information, call our Client Relations Manager, Courtney Bachik, at (412-458-6000).

DON'T WORRY ABOUT TOTAL ACCURACY – JUST DO THE BEST YOU CAN

WE LOOK FORWARD TO SEEING YOU!!!

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

Julian Gray Associates
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Pittsburgh, PA 15220
Phone: 412-458-6000
Fax: 412-458-6015

www. GrayElderLaw.com

SPECIAL NEEDS PLANNING QUESTIONNAIRE

PLEASE BE AWARE no attorney client relationship has been formed by completing or not completing this questionnaire. If we do not receive your completed questionnaire within **thirty (30) days** from the date of receipt, we will close your file and Julian Gray Associates will take no further action on this matter.

Today's Date ____________________________

Home Phone No. __________________ Business Phone No. ___________________________

Cell Phone No. ____________________ Fax No. _____________________________________

E-mail address ____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.

A. PERSONAL DATA (If unmarried, complete applicable sections)

(Husband)

Full Name ___________________________
(print name as shown on your checks)

(Wife)

Full Name ___________________________
(print name as shown on your checks)

Street Address ____

City _____________________ County:_____________________ State ________ Zip____________

(Husband) Birth Date ___________________________

(Wife) Birth Date ___________________________

(Husband) Social Security No. ____________________

(Wife) Social Security No. ____________________

(Husband) U.S. Citizen? ☐ Yes ☐ No

(Wife) U.S. Citizen? ☐ Yes ☐ No

(Husband) Annual Income _______________________

(Wife) Annual Income _______________________

Will you be establishing the Special Needs Trust? ☐ Yes ☐ No

Your relationship to the beneficiary of the Special Needs Trust:

☐ Father ☐ Mother ☐ Brother

☐ Sister ☐ Aunt ☐ Uncle

☐ Grandfather ☐ Grandmother ☐ Other ______________________

B. DISABLED CHILD

1. Full Name: ____

Street Address ____

City ______________________ State ______ Zip______________

Home Phone No. ______________ Fax No. ______________________

E-mail address ______________ Cell No. ______________________

Birth Date __________________ Social Security No. ______________

Nickname ___________________ Medicaid No. __________________

Gender: ☐ Male ☐ Female

Select one: ☐ Natural child ☐ Adopted child ☐ Stepchild ☐ Child born out of wedlock

The disabled person's diagnosis is: ______________________________

The disabled person's treating physician:__________________________

Disabled persons' spouse's name (if applicable) ____________________

Is the disabled person receiving public benefits? ☐ Yes ☐ No

Disabled person's monthly income from public benefits: $______________

Is the disabled person employed? ☐ Yes ☐ No

Disabled person's monthly income from employment: $______________

2. Is the disabled person likely to apply for public benefits? ☐ Yes ☐ No

The public benefits the disabled person is receiving or is likely to apply for are:

☐ SSI ☐ Medicaid ☐ SSD

☐ Medicare ☐ Medicaid Waiver ☐ Section 8 Housing

☐ Group Home ☐ Psychiatric ☐ Institutionalization

☐ Other Public Benefits ____________________________________

If the disabled person is not yet receiving public benefits, has there been a determination of disability by the Social Security Administration? ☐ Yes ☐ No

3. Are the assets to fund the trust the assets of the parent or other third party? ☐Yes ☐ No

4. Trustee will be a: ☐ Family member ☐ Professional trustee

C. ESTATE PLANNING DOCUMENTS

1. The disabled person has a:

☐ Will
☐ Health Care Power of Attorney
☐ Trust
☐ Living Will
☐ Financial Power of Attorney

2. Parents/guardians have:

☐ Will(s)
☐ Health Care Power(s) of Attorney
☐ Third-Party Special Needs Trust
☐ Financial Power(s) of Attorney
☐ Living Will(s)
☐ Revocable Living Trust(s)

D. CLIENT'S NON-DISABLED CHILDREN

Full Name of Child ___________________________ Gender: ☐ M ☐ F

Street Address ____

City ___________________________________ State ______ Zip________________

Home Phone No. ________________________ Fax No. ______________________________

E-mail address __________________________ Cell No. _____________________________

Birth Date ______________________________ Social Security No. ____________________

Nickname _______________________________ Medicaid No. _________________________

Select one: ☐ Natural child ☐ Adopted child ☐ Stepchild ☐ Child born out of wedlock

Full Name of Child ___________________________ Gender: ☐ M ☐ F

Street Address ____

City ___________________________________ State ______ Zip________________

Home Phone No. ________________________ Fax No. ______________________________

E-mail address __________________________ Cell No. _____________________________

Birth Date ______________________________ Social Security No. ____________________

Nickname _______________________________ Medicaid No. _________________________

Full Name of Child ____________________________ Gender: ☐ M ☐ F

Street Address ____

City ____________________________________ State ______ Zip________________

Home Phone No. ________________________ Fax No. ________________________________

E-mail address __________________________ Cell No. ________________________________

Birth Date ______________________________ Social Security No. ______________________

Nickname ______________________________ Medicaid No. ___________________________

Full Name of Child ____________________________ Gender: ☐ M ☐ F

Street Address ____

City ____________________________________ State ______ Zip________________

Home Phone No. ________________________ Fax No. ________________________________

E-mail address __________________________ Cell No. ________________________________

Birth Date ______________________________ Social Security No. ______________________

Nickname ______________________________ Medicaid No. ___________________________

I have no Non-Disabled Children ☐

Does the husband have any children by a previous marriage? ☐ Yes ☐ No

Does the wife have any children by a previous marriage? ☐ Yes ☐ No

Do any of your family members have any problems with:

Drug Addiction? ☐ Yes ☐ No

Alcoholism? ☐ Yes ☐ No

Spendthrift? ☐ Yes ☐ No

Do you have a disabled grandchild or grandchildren? ☐ Yes ☐ No

Full Name of Disabled Grandchild _______________________________ Gender: ☐ M ☐ F

Street Address ____

City ____________________________________ State ______ Zip________________

Home Phone No. ________________________ Fax No. ________________________________

E-mail address __________________________ Cell No. ________________________________

Birth Date ______________________________ Social Security No. ______________________

Select one: ☐ Natural child ☐ Adopted child ☐ Stepchild ☐ Child born out of wedlock

E. SPOUSE AND CHILDREN

Do you wish to provide primarily for your spouse and secondarily for your children? ☐ Yes ☐ No

Do you wish to treat all of your children equally? ☐ Yes ☐ No

If not, why not? ____

After your spouse's death, at what age do you want distribution to your children? ______
(e.g. a typical plan provides for 1/2 at age 30 and 1/2 at age 35 or immediate)

Do you want your disabled child's share to go to a Special Needs Trust? ☐ Yes ☐ No

You want to fund the trust with:

- ☐ A percentage of your estate—Percentage: ______ %
- ☐ Life insurance

Do you have an existing life insurance policy to fund the trust? ☐ Yes ☐ No

Specific dollar amount—$ ____

F. PARENTS

Does the Husband have living parents? Yes ☐ No ☐

If yes, please check the applicable boxes:

Mother	☐	Father	☐
PA Resident?	☐	PA Resident?	☐
Age?	_____	Age?	_____

Does the Wife have living parents? Yes ☐ No ☐

If yes, please check the applicable boxes:

Mother	☐	Father	☐
PA Resident?	☐	PA Resident?	☐
Age?	_____	Age?	_____

G. LIFE INSURANCE/LONG TERM CARE INSURANCE

Name of Company ___________________________________ Policy#______________________

Street Address ____

City ___________________________ State __________________ Zip _____________________

Type of Policy _________________ Owner ____

Insured ________________________ Beneficiary ____

Death Benefit: $_____________ Face Value $____________ Cash Value $_______________

Name of Company ________________________________ Policy#_____________________

Street Address ____

City _________________________ State _________________ Zip ____________________

Type of Policy ________________ Owner ____

Insured ______________________ Beneficiary _____________________________________

Death Benefit: $____________ Face Value $___________ Cash Value $______________

Name of Company ________________________________ Policy#_____________________

Street Address ____

City _________________________ State _________________ Zip ____________________

Type of Policy ________________ Owner ____

Insured ______________________ Beneficiary _____________________________________

Death Benefit: $____________ Face Value $___________ Cash Value $______________

Name of Company ________________________________ Policy#_____________________

Street Address ____

City _________________________ State _________________ Zip ____________________

Type of Policy ________________ Owner ____

Insured ______________________ Beneficiary _____________________________________

Death Benefit: $____________ Face Value $___________ Cash Value $______________

H. MISCELLANEOUS

Do you have any other legal issues which I should be aware of ? ☐ Yes ☐ No

If yes, please explain ____

____

What is the location of your important papers?_______________________________________

Do you have a safe deposit box? ☐ Yes ☐ No

If yes, please indicate the name and address of the location _____________________________

____

Have you ever made gifts to any one person in excess of $500 in any one calendar year? ☐ Yes ☐ No

Have you ever filed a federal gift tax return? ☐ Yes ☐ No

I. REFERRAL

By whom were you referred to this office?

Name ____

Company Name ____

Street Address ____

City ________________________________ State ________________ Zip ________________

Telephone No. ________________________ E-mail address ________________________

Referral is a: ☐ Attorney ☐ Insurance Broker ☐ Trust Company ☐ Financial Advisor

☐ Disability Organization ☐ Other ______

J. YOUR ADVISORS:

	Name	Telephone No.
Accountant	________________________	_________________________
Life Insurance Agent	_______________________	_________________________
Investment Advisor	_______________________	_________________________
Other Attorney	_______________________	_________________________
Other Consultant or Advisor	_______________________	_________________________
Physician	_______________________	_________________________
Service Providers	_______________________	_________________________

K. CERTIFICATION

The undersigned hereby represents to Gray Elder Law, LLC, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative: ____

Although reasonable value approximations are acceptable, it is important to be certain of the identity of all assets and how they are owned or titled. This Questionnaire provides for identification of assets as owned solely by wife, solely by husband, or as co-owned (either with a spouse or with another).

ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space.

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
Personal Effects/Household Items	$			
Automobile	$			
Checking Account	$			
Savings Account	$			
Money Market Account	$			
Certificates of Deposit	$			
Residence (Assessed Value) Block #_________ Lot #________ (Obtain from Tax Bill)	$			
Other Real Estate	$			
Additional Automobiles	$			
Mutual Funds	$			
Stocks	$			
Bonds	$			
Annuities	$			
Cash Value - Life Insurance	$			
IRA	$			
Nursing Home Deposit	$			
Other	$			
Other	$			
TOTALS	$			

What did you pay for your current home including any improvements? $__________________
Do you own any real property other than personal residence? ___________________________

Although reasonable value approximations are acceptable, it is important to be certain of the identity of all assets and how they are owned or titled. This Questionnaire provides for identification of assets as owned solely by wife, solely by husband, or as co-owned (either with a spouse or with another).

ASSETS/LIABILITIES (complete on behalf of Disabled Person)

Please insert the value of each asset/liability in the appropriate space.

ASSETS	SELF	JOINTLY HELD	LIABILITIES
Personal Effects/Household Items	$		
Automobile	$		
Checking Account	$		
Savings Account	$		
Money Market Account	$		
Certificates of Deposit	$		
Residence (Assessed Value) Block #_________ Lot #________ (Obtain from Tax Bill)	$		
Other Real Estate	$		
Additional Automobiles	$		
Mutual Funds	$		
Stocks	$		
Bonds	$		
Annuities	$		
Cash Value - Life Insurance	$		
IRA	$		
Nursing Home Deposit	$		
Other	$		
Other	$		
TOTALS	$		

What did you pay for your current home including any improvements? $__________________
Do you own any real property other than personal residence? ____________________________