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) **(Wife)**

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

Street Address _____

City _____ County:_____ State _____ Zip_____

Birth Date _____ Birth Date _____

Social Security No. _____ Social Security No. _____

U.S. Citizen? Yes ☐ No ☐ U.S. Citizen? Yes ☐ No ☐

Annual Income _____ 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 <u>all</u> assets and <u>how they are owned or titled</u>. 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 <u>all</u> assets and <u>how they are owned or titled</u>. 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? _____