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
954 Greentree Road
Pittsburgh, PA 15220
Phone: 412-458-6000
Fax: 412-458-6015

www. GrayElderLaw.com

SPECIAL NEEDS TRUST WORKSHEET

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.

Date _____

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

(Self)

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

Street Address _____

City _____ County:_____ State _____ Zip_____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-mail address _____

Birth Date _____ Social Security No. _____

U.S. Citizen? □ Yes □ No

Annual Income _____

Are you married? □ Yes □ No

Name of Spouse: _____

Do you have a legal guardian? □ Yes □ No

Are any of your natural or adopted parents living? □ Yes □ No

Your Medical diagnosis is: _____

Your treating physician: _____

Are you employed? □ Yes □ No

Monthly income from employment: $_____

Are you receiving public benefits? □ Yes □ No

Monthly income from public benefits: $_____

The public benefits you are receiving or are likely to apply for are:

☐ SSI	☐ Medicaid	☐ SSD
☐ Medicare	☐ Medicaid Waiver	☐ Section 8 Housing
☐ Group Home	☐ Psychiatric	☐ Institutionalization

☐ Other Public Benefits _____

Is there a case worker involved? □ Yes □ No

Name and address of caseworker: _____

If you are not receiving public benefits, has there been a determination of disability by the Social Security Administration? □ Yes □ No

Are the assets to fund the trust the assets of a parent or other third party? □Yes □ No

Trustee will be a: ☐ Family member ☐ Professional trustee

Have you or will you be receiving a settlement from a law suit? □ Yes □ No

If yes, amount of settlement $_____

Is there legal counsel involved □ Yes □ No

Name of legal counsel _____

B. ESTATE PLANNING DOCUMENTS

1. The disabled person has a:

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

2. Non-parent family members have:

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

C. PARENTS

Do you have living parents? Yes ☐ No ☐

If yes, please check the applicable boxes:

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

D. REMAINDER BENEFICIARIES OF THE TRUST

Full Name _____ Gender: ☐ M ☐ F

Relationship to Disabled SNT Beneficiary _____

Street Address _____

City _____ State _____ Zip_____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Birth Date _____

Full Name _____ Gender: ☐ M ☐ F

Relationship to Disabled SNT Beneficiary _____

Street Address _____

City _____ State _____ Zip_____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Birth Date _____

Full Name _____ Gender: □ M □ F

Relationship to Disabled SNT Beneficiary _____

Street Address _____

City _____ State _____ Zip_____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Birth Date _____

E. CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? □ Yes □ No
If yes, please list:

Name of Charity	Address of Charity	Dollar Amount

F. 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 $_____

G. POSSIBLE TRUSTEES

Would you consider a corporate or non-profit Trustee ? □ Yes □ No

Potential Individual Trustees:

Full Name _____ Gender: □ M □ F

Relationship to Disabled SNT Beneficiary _____

Street Address _____

City _____ State _____ Zip_____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Birth Date _____

Full Name _____ Gender: □ M □ F

Relationship to Disabled SNT Beneficiary _____

Street Address _____

City _____ State _____ Zip_____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Birth Date _____

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? _____

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

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 _____ _____

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	SELF	JOINTLY HELD FUNDS	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? _____