



# ANDERSON ELDER LAW

ELDER LAW • ESTATE PLANNING • SPECIAL NEEDS PLANNING

## SPECIAL NEEDS BENEFICIARY QUESTIONNAIRE FOR FIRST PARTY & THIRD PARTY TRUSTS

This form is extremely important. Your accuracy and completeness in responding will help Anderson Elder Law represent you. Please bring this completed information packet, including each of the attached schedules, to your initial consultation.

Date: \_\_\_\_\_ File No.: \_\_\_\_\_

### **A. BENEFICIARY**

Full Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Medicaid No.: \_\_\_\_\_ Medicare Claim No.: \_\_\_\_\_

Gender:  Male  Female

Spouse's Name: \_\_\_\_\_

**1. Describe Beneficiary's Underlying Disability:** \_\_\_\_\_

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

**2. Describe Beneficiary's Current Disability (therapeutic, educational, vocational and social issues):**

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

- |  |                           |                          |
|--|---------------------------|--------------------------|
| • Was onset of disability prior to age 22?           | <input type="radio"/> Yes | <input type="radio"/> No |
| • Is Beneficiary competent to handle funds?          | <input type="radio"/> Yes | <input type="radio"/> No |
| • Does Beneficiary require supervision?              | <input type="radio"/> Yes | <input type="radio"/> No |
| • Does Beneficiary have issues with substance abuse? | <input type="radio"/> Yes | <input type="radio"/> No |
| • Is Beneficiary developmentally disabled?           | <input type="radio"/> Yes | <input type="radio"/> No |

**Special Needs Beneficiary Questionnaire for First Party & Third Party Trusts**

206 Old State Road • Media, PA 19063 • T: 610-566-4700 • F: 610-566-4702

3. Prognosis: \_\_\_\_\_

**4. Where does the Beneficiary live now?**

- With parents
  - Owns a residence or leases an apartment (with support or independently) living
  - Lives in a residence with a particular person \_\_\_\_\_
  - Group home
  - Private facility
  - Other: \_\_\_\_\_
- Contact Person (if at Institution): \_\_\_\_\_

**5. Citizenship**

Is the Beneficiary:

- US Citizen
- Qualified Alien
- Don't Know

**6. Competency**

Beneficiary is a:

- Minor, expected to have full capacity at majority
- Incapacitated adult
- Minor, expected to be incapacitated at majority
- Competent adult

**7. Social Security**

Address of Social Security Office with which Beneficiary has contact:

Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

**8. Guardianship (if applicable)**

Is the Beneficiary the subject of a guardianship?  Yes  No

If yes, please provide the following:

Name of Guardian: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Name of Co-Guardian (if applicable): \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

**Please attach court orders, guardianship letters, and related pleadings.**

9. If the Beneficiary is incapacitated, yet is not subject to a guardianship, is a guardianship required?  Yes  No  
If yes, please complete Guardianship Questionnaire.

10. Estate Planning Documents for Beneficiary (if Beneficiary is an adult)

If the Beneficiary is competent, does he or she have a:

- Will
- Living Will
- Health Care Power of Attorney
- Financial Power of Attorney
- First Party Special Needs Trust

Would you like intake forms sent to you so that these documents can be prepared?

Yes  No

**B. ESTATE PLANNING**

Do the family members each have a:

- Will
- Living Will
- Health Care Power of Attorney
- Financial Power of Attorney
- Third Party Special Needs Trust

If no, would you like our office to send you Questionnaires to you so that these documents can be prepared?

Yes  No

**C. PERSONAL INJURY SUIT INFORMATION (IF APPLICABLE)**

1. Pending Litigation Information:

County: \_\_\_\_\_

Case Number: \_\_\_\_\_ Status of Case: \_\_\_\_\_

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

2. Attorney

Personal Injury Attorney: \_\_\_\_\_

Name of Law Firm: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

### 3. Defense Attorney

Defense Attorney: \_\_\_\_\_

Name of Law Firm: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

### 4. Structured Settlement Broker

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

### **D. REFERRAL**

Who referred you to our office?

Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Have you visited our website at [www.AndersonElderLaw.com](http://www.AndersonElderLaw.com)?  Yes  No

Do you have any ideas for improving our website? If so, please discuss: \_\_\_\_\_

### **E. CERTIFICATION**

The undersigned hereby represents to Anderson Elder Law 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 Anderson Elder Law may not be appropriate.

\_\_\_\_\_  
*Signature of Client or Client Representative*

\_\_\_\_\_  
*Date*

### **ATTENTION: INSTRUCTIONS FOR SCHEDULES 1 & 2**

A **Third Party Supplemental Needs Trust** is established by anyone other than the Special Needs Beneficiary ("Beneficiary") and is funded with resources that are owned by the third party (such as Parents, Siblings, or Grandparents). If you are creating a Third Party Supplemental Needs Trust for a Family Member, please complete **SCHEDULE 1**.

However, if the trust required is to protect funds **owned** by the Special Needs Beneficiary, then complete **SCHEDULE 2** for a **First Party Trust**, also referred to as a **Self-Settled Special Needs Trust**.

**SCHEDULE 1: Third Party Supplemental Needs Trust Information**

Please note, we will spend time during our first meeting completing this Schedule. However, you may want to review the following list of questions in anticipation of our meeting.

**1. Who is establishing the Trust?** \_\_\_\_\_

Parent(s): \_\_\_\_\_

Grandparent(s): \_\_\_\_\_

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

**2. Do you want your Trust to be irrevocable or revocable?** \_\_\_\_\_

**3. Initial assets to be contributed to the Trust?** \_\_\_\_\_

**4. Who will be initial Trustee(s)?** \_\_\_\_\_

Parent(s): \_\_\_\_\_

Corporate Trustee: \_\_\_\_\_

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

**5. Who are the Successor Trustees (include a corporate Trustee?)** \_\_\_\_\_

**6. Should the Trust require Trustee to post a bond?**

\_\_\_\_\_

**7. Who should receive the Trust estate when your Beneficiary dies?**

Beneficiary's descendants

Your descendants

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

**8. Would you like your Trust to give your Beneficiary a Power of Appointment (i.e., a final say in who receives the Trust assets upon Beneficiary's death?). If yes, would you like the Power to be limited to a certain group of people (ex., siblings), or may the Beneficiary gift the remaining trust assets to any person or entity?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHEDULE 1 (continued)**

**9. What is your hope for the Beneficiary's optimal living arrangement in the future?**

- Own a residence or lease an apartment (with support or independently);
- Live in a residence with a particular person: \_\_\_\_\_
- Group home
- Private facility
- Other: \_\_\_\_\_

**10. Are any of the following unacceptable living arrangements?**

- Group Home
- Public Institution
- Public Care Facility

**11. Should your Trust include provisions describing the types of social activities that might be important to your Beneficiary? Such as:**

- Participation at sporting activities (including Special Olympics)
- Attending sporting events, or cultural events
- Participating in religious activities
- Attending religious services
- Other: \_\_\_\_\_

**12. We recommend the use of a Trust Protector (ability to amend trust and remove Trustee, if necessary). If you agree, how should the Trust Protector be chosen? (Select one)**

- Your selection for Trust Protector (if known): \_\_\_\_\_
- Attorney for Trustee may select later
- The Court shall select upon petition

**13. We recommend that your Trust include provisions regarding a Trustee's use of professional services to manage the care of the Beneficiary.**

- a. If you agree, would you like your Trust to suggest or require the use of professional services?  
\_\_\_\_\_
- b. If you agree, please indicate your preference for type of professional services you prefer for your Beneficiary:
- Licensed Social Worker
  - Care Manager
  - Attorney-Advocate
  - Advisory Committee
  - Non-profit/Agency
  - Registered Nurse
  - Other: \_\_\_\_\_

**14. We recommend that your Trust include provisions regarding a Trustee’s use of an annual care plan to manage the care of the Beneficiary.**

a. If you agree, would you like your Trust to suggest or require the use of annual care’ plan to manage the care of the Beneficiary?

\_\_\_\_\_

b. Would you like the Trust to require face-to-face periodic assessments? \_\_\_\_\_

c. Would you like the Trust to require visits to the Beneficiary? If yes, what is your preferred schedule?

\_\_\_\_\_

**15. Would you like your Trust to include provisions permitting your Trustee to make gift purchases on behalf of your Beneficiary to other family members or friends? If yes, what is maximum value of gift to be given per person and how frequently may gifts be given? \_\_\_\_\_**

**16. Would you like your Trust to include a “relief valve” so that if the Trust is challenged, the Trust can be terminated and distributed to a trusted family member or friend?**

If yes, name of trusted person: \_\_\_\_\_

**17. Would you like your Trust to allow early termination if:**

- Trust renders Beneficiary ineligible for public benefits
- Beneficiary is substantially gainfully employed on a long-term basis
- None of the above

**18. Miscellaneous:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**SCHEDULE 2: First Party Trust (also referred to as a Self-Settled Special Needs Trust)**

Please note, we will spend time during our first meeting completing this Addendum. However, you may want to review the following list of questions in anticipation of our meeting.

**1. Who is establishing the Trust?**

- Parent(s): \_\_\_\_\_
- Grandparent(s): \_\_\_\_\_
- Court: \_\_\_\_\_
- Guardian(s): \_\_\_\_\_

**2. Initial assets to be contributed to the Trust?** \_\_\_\_\_  
\_\_\_\_\_

**3. Who will be initial Trustee(s):**

- Parent(s): \_\_\_\_\_
- Corporate Trustee: \_\_\_\_\_
- Other: \_\_\_\_\_

**4. Who are the Successor Trustees (include a corporate trustee)?** \_\_\_\_\_  
\_\_\_\_\_

**5. Who should receive the Trust estate when your Beneficiary dies?**

- Beneficiary's descendants
- Your descendants
- Other: \_\_\_\_\_

**6. What is your hope for the Beneficiary's optimal living arrangement in the future?**

- Own a residence or lease an apartment (with support or independently);
- Live in a residence with a particular person: \_\_\_\_\_
- Group home
- Private facility
- Other: \_\_\_\_\_

**SCHEDULE 2 (continued)**

**7. Are any of the following unacceptable?**

- Group Home
- Public Institution
- Public Care Facility

**8. Should your Trust include provisions describing the types of social activities that might be important to your Beneficiary? Such as:**

- Participation at sporting activities (including Special Olympics)
- Attending sporting events, or cultural events
- Participating in religious activities
- Attending religious services
- Other: \_\_\_\_\_

**9. Would you like your Trust to permit early termination of the Trust? If yes, the following reasons are typical provisions:**

- Beneficiary is no longer disabled
- Beneficiary eligibility for public benefits is terminated
- Beneficiary is gainfully employed
- Insufficient assets to justify Trust continuation.

**Note: The termination of the Trust estate will require an immediate payback to the State for any Medicaid benefits received up to point of termination.**

**10. Should the Trust require Trustee to post a bond?**

\_\_\_\_\_

**11. We recommend the use of a Trust Protector (ability to amend trust and remove Trustee, if necessary). If you agree, how should the Trust Protector be chosen? (Select one)**

- Your selection for Trust Protector (if known): \_\_\_\_\_
- Attorney for Trustee may select later
- The Court shall select upon petition

**SCHEDULE 2 (continued)**

**12. We recommend that your Trust include provisions regarding a Trustee's use of professional services to manage the care of the Beneficiary.**

a. If you agree, would you like your Trust to suggest or require the use of professional services?

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b. If you agree, please indicate your preference for type of professional services you prefer for your Beneficiary:

Licensed Social Worker                       Care Manager                       Attorney-Advocate

Advisory Committee                       Non-profit/Agency                       Registered Nurse

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

**14. We recommend that your Trust include provisions regarding a Trustee's use of an annual care plan to manage the care of the Beneficiary.**

a. If you agree, would you like your Trust to suggest or require the use of annual care' plan to manage the care of the Beneficiary?

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b. Would you like the Trust to require face-to-face periodic assessments? \_\_\_\_\_

c. Would you like the Trust to require visits to the Beneficiary? If yes, what is your preferred schedule?

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**15. Would you like your Trust to include provisions permitting your Trustee to make gift purchases on behalf of your Beneficiary to other family members or friends? If yes, what is maximum value of gift to be given per person and how frequently may gifts be given? \_\_\_\_\_**

**16. Would you like your Trust to include a "relief valve" so that if the Trust is challenged, the Trust can be terminated and distributed to a trusted family member or friend?**

If yes, name of trusted person: \_\_\_\_\_

**17. Would you like your Trust to allow early termination if:**

Trust renders Beneficiary ineligible for public benefits

Beneficiary is substantially gainfully employed on a long-term basis

None of the above