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CLIENT INFORMATION ORGANIZER
SPECIAL NEEDS PLANNING

ESTATE PLANNING and ADMINISTRATION

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STEP 1

PERSONAL DATA

This questionnaire is intended to elicit preliminary information necessary to help us with special needs and possible Medicaid planning pertinent to your particular circumstances. The more complete and accurate your responses, the better we will be able to serve you. Feel free to attach extra sheets if necessary.

Personal Data of Person With Special Needs

Full Legal Name _____
(Name most often used to title property and accounts)

Also Known As _____
(Other names used to title property and accounts)

Prefer to be called _____ Birth date _____ SS# _____ US Citizen? _____

Home Address _____ City _____ State _____ Zip _____

Home Telephone _____ County of Residence _____

Business Telephone _____ Cell Phone _____

Employer _____ Retirement Date _____

E-mail Address _____ ☐ It is okay to communicate via E-mail

Married? ☐ Yes ☐ No Date of Marriage _____ Existing Pre- or Postnuptial Agreement? _____

Veteran ☐ Yes ☐ No Branch of Service _____ Dates of Service _____

Serial No. _____ VA Claim No. _____

Do you have a financial Power of Attorney? ☐ Yes ☐ No Name of agent _____

Are you subject to a Guardianship or Conservatorship? ☐ Yes ☐ No

Name of Guardian or Conservator _____

Contact Information for Person(s) Assisting Person with Special Needs

Primary Contact Person's Name _____

Relationship to Person with Special Needs _____

Prefer to be called _____ Birth date _____ SS# _____ US Citizen? _____

Home Address _____ City _____ State _____ Zip _____

Home Telephone _____ County of Residence _____

Business Telephone _____ Cell Phone _____

Employer _____ Position _____

E-mail Address _____ ☐ It is okay to communicate with me via my E-mail address

Secondary Contact Person's Name _____

Relationship to Person with Special Needs _____

Prefer to be called _____ Birth date _____ SS# _____ US Citizen? _____

Home Address _____ City _____ State _____ Zip _____

Home Telephone _____ County of Residence _____

Business Telephone _____ Cell Phone _____

Employer _____ Position _____

E-mail Address _____ ☐ It is okay to communicate with me via my E-mail address

STEP 1

PERSONAL DATA—CONTINUED

This questionnaire is intended to elicit preliminary information necessary to help us with special needs and possible Medicaid planning pertinent to your particular circumstances. The more complete and accurate your responses, the better we will be able to serve you. Feel free to attach extra sheets if necessary.

If the Person with Special Needs is Currently in a Health Care Facility

Name of Facility _____

Address _____ City _____ State _____ Zip _____

Type of facility _____ Phone _____

Date of Admission _____ Level of care _____

If entered this facility from another health care facility:

Date of his or her admission to the initial facility _____

Current source of payments for health care facility charges _____

_____

STEP 2

FAMILY INFORMATION

Identify all living spouses, parents, grandparents, siblings or children of the special needs person.

Special Note When Identifying Children: For "Children" use "JT" if both spouses are the parents, "H" if husband is the parent, "W" if wife is the parent, "S" if a single parent.

Name	Birth date	Relationship
1		
2		
3		
4		
5		
6		
7		
8		

Please use the back of this page for additional names.

STEP 2

FAMILY INFORMATION—CONTINUED

Identify all living spouses, parents, grandparents, siblings or children of the special needs person.

Special Note When Identifying Children: For "Children" use "JT" if both spouses are the parents, "H" if husband is the parent, "W" if wife is the parent, "S" if a single parent.

Do any of the above individuals have special educational, medical or physical needs, receive governmental benefits or have any extraordinary personal or financial needs? ☐ Yes ☐ No

If yes, please describe _____

_____

_____

Is the special needs person dependent upon anyone for support? ☐ Yes ☐ No

If yes, please identify the person, and provide a general overview as to the reason for, and extent of, support provided

_____

_____

_____

_____

_____

_____

STEP 3

MEDICAL DATA

The information you provide in this section will allow us to identify specialized planning needs and customize the person's Special Needs Trust to ensure that the trust permits distributions that are most likely to improve the person's quality of life.

Formal, medical name of disabling condition(s): _____

_____

Please describe and explain the disabling condition(s) in non-medical terms, including what this person is able to do and unable to do: _____

_____

_____

Please list or describe any specific activities this person enjoys that enhances his or her quality of life or that helps improve his or her condition: _____

_____

_____

STEP 3

MEDICAL DATA—CONTINUED

The information you provide in this section will allow us to identify specialized planning needs and customize the person's Special Needs Trust to ensure that the trust permits distributions that are most likely to improve the person's quality of life.

Please describe the special needs person's overall physical health:_____

_____

_____

Please describe the special needs person's overall mental health:_____

_____

_____

Can this person work? ☐ Yes ☐ No
Please explain:_____

Can this person drive? ☐ Yes ☐ No
If no, please describe the transportation needs:_____

Can this person live independently? ☐ Yes ☐ No
If no, please describe the arrangement where he or she is currently living, as well as the projected duration of this arrangement:_____

_____

_____

STEP 4

GOVERNMENT ASSISTANCE

A Special Needs Trust is only to protect eligibility for certain types of government benefits. The information you provide in this section will help us ensure that special needs planning is appropriate for the person you have identified.

From what government programs is this person currently receiving assistance? (For example, Medicaid, Medicare, Social Security, Supplemental Security Income (SSI), Supplemental Security Disability Income (SSDI), rental assistance/HUD, food stamps, ect.) Please be careful to distinguish between Medicaid and SSI, which are means-tested programs, and Medicare and SSDI, which are federal entitlement programs.

_____

_____

_____

_____

Did this person receive any public aid or assistance before turning 18? ☐ Yes ☐ No
If so, what kind of assistance:_____

_____

Local Office/Contact Name and Case Number:_____

_____

_____

If this person is not receiving Medicaid, how are his or her medical expenses being met?

_____

_____

_____

_____

STEP 5

APPOINTMENTS—PEOPLE TO ASSIST

One of the most important aspects of any special needs plan is the "appointment" of various persons to assist the person with special needs, his or her family and you. These appointed "helpers" are called by different names depending on the type of plan you elect to implement.

Who will serve as a Trustees to manage the Special Needs Trust?

		Name and address
Trustees	First Choice	
	Second Choice	
	Third Choice	

Advisory Panel or Care Manager/Advocate

If the Trustees do not have the expertise to evaluate the beneficiary's heath or the adequacy of care providers, consider nominating an Advisory Panel and/or a Care Manager/Advocate.

The members of an Advisory Panel can advise the Trustees about the beneficiary's changing needs. Family members often do an excellent job serving on an Advisory Panel.

Who would you like to serve on an Advisory Panel?

		Name and address
Advisory Panel Members	Advisory Panel Member	
	Advisory Panel Member	
	Advisory Panel Member	
	Advisory Panel Member	
	Advisory Panel Member	
	Advisory Panel Member	
	Advisory Panel Member	

Would you like to authorize the Trustee to hire an Advocate or Care Manager?

☐ Yes ☐ No

If so, and you have a particular person in mind, list them here.

Advocate/ Care Manager	First Choice	
	Second Choice	
	Third Choice	

STEP 6

SPECIAL INSTRUCTIONS

CHANGE IN CIRCUMSTANCES

The beneficiary's inheritance will remain in the Special Needs Trust for his or her lifetime unless you provide for circumstances under which a full or partial distribution may be made. If the beneficiary is employed and self-supporting for a period of time (for example, 24 months out of the last 28 months), you have a choice to permit the Successor Trustees to distribute all or some of the trust assets. What circumstances, if any, would you like to trigger a distribution?

RESIDENTIAL PREFERENCES

What instructions would you like to provide regarding the beneficiary's residence? Are certain options unacceptable (such as a public facility)? Would you prefer for the beneficiary to be a homeowner someday? Would you like a caregiver to live in the home with the beneficiary?

SOCIAL OPPORTUNITIES

What opportunities would you like to provide the beneficiary?

DISTRIBUTION OF ANY REMAINDER IN THE SPEDIAL NEEDS TRUST

Who would like to receive any remaining funds when the trust terminates. Please use legal names.

Do any of the above named persons have any special needs of their own? ☐ Yes ☐ No
If so, please describe _____

FUNERAL/CEMETARY

Does the person with special needs own a cemetery lot, or has this person prepaid any funeral or burial expenses? ☐ Yes ☐ No
If so, please describe _____

STEP 7

ASSETS OF PERSON WITH SPECIAL NEEDS

Determining the ownership, value and character of the assets of the special needs person is important for Medicaid and special needs planning. The title "ownership" is important for tax and transfer matters. The "value" will be significant in determining potential liability. The "character" is relevant in assessing the manner by which the asset can transfer. Complete the questions below for the special needs person and his or her spouse if any.

ASSETS	Individually Owned		Joint Ownership	
	# of Assets	Total Value	# of Assets	Total Value
Cash Accounts (i.e. checking, savings, CD, Money Market)				
Investment Accounts (i.e. brokerage accounts)				
Bonds (not held in an investment account)				
Stocks (not held in an investment account)				
Company Stock Options				
Personal Effects (i.e. jewelry, household items, art, vehicles, boats, planes, RV's, other "toys," ect.				
Retirement Plans (401k, IRAs, etc.)				
Pension Plans				
Life Insurance Policies (death value)				
Annuities				
Partnership & LLC Interests				
Corp. Business Interests (S-Corp or LLC)				
Sole Proprietorship Interest				
Oil, Gas, and Mineral Interests				
Monies Owed to You (promissory notes)				
Personal Residence				
Other Montana Real Property				
Other Out-of-State Real Property				
Other Assets				
Anticipated Inheritance, Gift, or Judgment				
TOTAL ASSET VALUE				
LIABILITIES				
Loans Payable				
Accounts Payable				
Real Estate Mortgages				
TOTAL LIABILITIES				

NET ESTATE (Total Assets minus Total Liabilties)		

STEP 8

INCOME

Determining the income sources the special needs person and his or her spouse have, or are entitled to, will determine his or her eligibility for Medicaid. Please list amount of income. If not received monthly, indicate how often.

Income Source	Received	Husband	How often Recieved	Wife	How often Received
1. Social Security	☐ Yes ☐ No				
2. SSI	☐ Yes ☐ No				
3. Veterans Benefits	☐ Yes ☐ No				
4. Railroad Retirement	☐ Yes ☐ No				
5. Civil Service Annuity	☐ Yes ☐ No				
6. Other Pension	☐ Yes ☐ No				
7. Annuities	☐ Yes ☐ No				
8. Trusts	☐ Yes ☐ No				
9. Insurance Payments	☐ Yes ☐ No				
10. IRA/KEOGH Payments	☐ Yes ☐ No				
11. Lease Income	☐ Yes ☐ No				
12. Rental Income	☐ Yes ☐ No				
13. Contract for Deed Payments	☐ Yes ☐ No				
14. Contributions from Others	☐ Yes ☐ No				
15. Gross Earning from Employment	☐ Yes ☐ No				
16. Self-employment Earnings	☐ Yes ☐ No				
17. Alimony Payments	☐ Yes ☐ No				
18. Mineral/timber rights income	☐ Yes ☐ No				
19. Income from Life Estate	☐ Yes ☐ No				
20. Any other income	☐ Yes ☐ No				

STEP 9

FUNDING FOR THE SPECIAL NEEDS TRUST

If known, how and when will the Special Needs Trust be funded? _____

_____

_____

_____

_____

_____

If funding by insurance, please provide the following:

Insurance Company	Owner	Type	Policy Number	Beneficiary	Cash Value
1.					
2.					
3.					