Scott, Tokerud & McCarty
Attorneys and Counselors

Client Information Organizer

Special Needs Planning

ESTATE PLANNING and ADMINISTRATION

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Thank you for thinking of us as you consider the needs of your loved one.

To help you with our organizer, we have included these brief instructions:

- Please use the Section Titled "Caregiver" to provide information for the main Caregivers.
- Please complete the sections titled "Special Needs Person" on behalf of the special needs person.
- Please complete the sections titled "Planning" to the best of your ability. This section is included to help you collect your thoughts prior to being asked to make final decisions.
- If you are unsure how to answer a question or want to discuss your answer in depth with the attorney, please mark the section with a star or a question mark.
- Please attach additional pages, if necessary.

All the information you provide remains 100% confidential.

CAREGIVER(S)

INFORMATION OF CAREGIVER

Name / Prefer to be called

Address City County State Zip

Birth Date Driver's License Number State of Issue

Primary Contact Number ☐ Home ☐ Work ☐ Cell Secondary Contact Number ☐ Home ☐ Work ☐ Cell

Email Address Preferred Method of Communication:

Briefly describe your relationship to the special needs person:

INFORMATION OF CAREGIVER

Name / Prefer to be called

Address City County State Zip

Birth Date Driver's License Number State of Issue

Primary Contact Number ☐ Home ☐ Work ☐ Cell Secondary Contact Number ☐ Home ☐ Work ☐ Cell

Email Address Preferred Method of Communication:

Briefly describe your relationship to the special needs person:

SPECIAL NEEDS PERSON

PERSONAL INFORMATION OF SPECIAL NEEDS PERSON

Name / Prefer to be called

Also Known As

How would he/she like his/her name to appear on documents

Address City County State Zip

Date of Birth XXX-XX- Social Security Number

Driver's License Number State of Issue

Primary Contact Number ☐ Home ☐ Work ☐ Cell

Secondary Contact Number ☐ Home ☐ Work ☐ Cell

Email Address

Current Marital Status:

- ☐ Never Married
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Please Check All That Apply:

- ☐ Pre/Postnuptial agreement
- ☐ Parents Still Living
- ☐ Grandparents Still Living
- ☐ Pet Owner
- ☐ Retired
- ☐ U.S. Veteran
- ☐ Spouse of U.S. Veteran

  Dates of service: _____

Preferred Method of Contact:

- ☐ Telephone
- ☐ Email

If he/she has a financial Power of Attorney, please name the agent:

Name Telephone

If he/she is subject to a Guardianship or Conservatorship, please name the Guardian/Conservator:

Name Telephone

If he/she received any public aid or assistance prior to reaching the age of 18, please list the programs (include offices, contact persons and case numbers if applicable):

SPECIAL NEEDS PERSON

FAMILY INFORMATION OF THE SPECIAL NEEDS PERSON:
Living Parents, Children & Siblings

1. _____
Name Relationship

_____
Address City State Zip

2. _____
Name Relationship

_____
Address City State Zip

3. _____
Name Relationship

_____
Address City State Zip

4. _____
Name Relationship

_____
Address City State Zip

5. _____
Name Relationship

_____
Address City State Zip

PLEASE ATTACH ADDITIONAL PAGES IF NEEDED.

Do any of the listed individuals have special educational, medical or physical needs, receive governmental benefits or have any extraordinary personal or financial needs? ☐ Yes ☐ No
If yes, briefly explain:

_____

_____

_____

SPECIAL NEEDS PERSON

MEDICAL INFORMATION OF SPECIAL NEEDS PERSON

Does the special needs person reside in a health care facility? ☐ Yes ☐ No

If yes, what type of facility? _____

_____

Name of Facility

_____

Facility Address City County State Zip

_____

Date of Admission Level of Care

Was the special needs person transferred to this facility from another? ☐ Yes ☐ No

If yes, what date was the person admitted into the initial facility? _____

Formal name of disabling condition(s): _____

_____

Please describe the condition in non-medical terms:

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

How are his/her healthcare costs being met?

_____

_____

_____

SPECIAL NEEDS PERSON

QUALITY OF LIFE INFORMATION OF SPECIAL NEEDS PERSON

Can the special needs person work? ☐ Yes ☐ No
Please explain:

Can the special needs person drive? ☐ Yes ☐ No
If no, please explain his/her transportation needs:

Can the special needs person live independently? ☐ Yes ☐ No
If no, please describe the incapacitated person's living arrangement, include how long this arrangement is expected to last:

Does the special needs person depend on anyone for support? ☐ Yes ☐ No
If yes, please identify on whom he/she depends and what kind of support those persons provide:

Please list or describe any activities this person enjoys that enhances his/her quality of life:

SPECIAL NEEDS PERSON

INCOME INFORMATION OF SPECIAL NEEDS PERSON

Does the special needs person receive any of the following? Please check and complete all that apply:

____	Social Security?	If yes, how much:	$	How often:	
____	SSI?	If yes, how much:	$	How often:	
____	SSDI?	If yes, how much:	$	How often:	
____	Veteran's Benefits?	If yes, how much:	$	How often:	
____	Gross Employment Earnings?	If yes, how much:	$	How often:	
____	Self-Employment Earnings?	If yes, how much:	$	How often:	
____	Lease Income?	If yes, how much:	$	How often:	
____	Rental Income?	If yes, how much:	$	How often:	
____	Mineral/Timber Interests?	If yes, how much:	$	How often:	
____	Contract for Deed Payments?	If yes, how much:	$	How often:	
____	Income from Life Estate?	If yes, how much:	$	How often:	
____	Railroad Retirement?	If yes, how much:	$	How often:	
____	Civil Service Annuity?	If yes, how much:	$	How often:	
____	Other Pensions?	If yes, how much:	$	How often:	
____	Annuities?	If yes, how much:	$	How often:	
____	Trust Income?	If yes, how much:	$	How often:	
____	Insurance Payments?	If yes, how much:	$	How often:	
____	IRA/KEOGH?	If yes, how much:	$	How often:	
____	Contributions from Others?	If yes, how much:	$	How often:	
____	Alimony Payments?	If yes, how much:	$	How often:	
____	Other Income?	If yes, how much:	$	How often:	
____	Other Government Programs?*	If yes, how much:	$	How often:	

* Please itemize each program using the back of this page. (Consider housing and food assistance programs.)

SPECIAL NEEDS PERSON

ASSET INFORMATION FOR THE SPECIAL NEEDS PERSON

ACCOUNTS	Number of Accounts (Circle One)				ESTIMATED VALUES
Cash Accounts	NONE	1-4	5-9	10+	$
Investment Accounts	NONE	1-4	5-9	10+	$
Stock & Bonds	NONE	1-4	5-9	10+	$
Retirement Accounts	NONE	1-4	5-9	10+	$
Life Insurance	NONE	1-4	5-9	10+	$
Annuities	NONE	1-4	5-9	10+	$
Promissory Notes	NONE	1-4	5-9	10+	$
BUSINESS INTERESTS	**Number of Businesses (Circle One)**				**ESTIMATED VALUES**
Sole Proprietorships	NONE	1-4	5-9	10+	$
Partnerships & LLCs	NONE	1-4	5-9	10+	$
Corporations	NONE	1-4	5-9	10+	$
REAL PROPERTY	**Number of Properties (Circle One)**				**ESTIMATED VALUES**
Personal Residence	NONE	1-4	5-9	10+	$
Other Montana Properties	NONE	1-4	5-9	10+	$
Out of State Properties	NONE	1-4	5-9	10+	$
Mineral Interests	NONE	1-4	5-9	10+	$
Do you have any water rights?	YES	NO			

OTHER ASSETS	Brief Description	ESTIMATED VALUES
Personal Effects		$
		$
Motor Vehicles		$
		$
Future Assets		$
		$
Other		$
	Total Estimated Assets	**$**

LIABILITIES	Brief Description	ESTIMATED VALUES
Mortgages		$
		$
Loans Payable		$
		$
Accounts Payable		$
		$
Other Liabilities		$
	Total Estimated Liabilities	**$**

Estimated Net Estate (Assets minus Liabilities) **$**

PLANNING

PRELIMINARY TRUST MANAGMENT DECISIONS

Trustee: Who do you trust to manage a Special Needs Trust on behalf of the Special Needs Person?

Choice One:_____
Name Telephone

Choice Two:_____
Name Telephone

Choice Three:_____
Name Telephone

In the event that the selected Trustees don't have the expertise to evaluate the special needs person's health or the adequacy of his/her care providers, you might consider naming an Advisory Panel and/or a Care Manager/Advocate.

Advisory Panel: Who do you trust to advise Trustees of the changing needs of the special needs person? (Family members are often an excellent choice.)

1. _____
Name Telephone

2. _____
Name Telephone

3. _____
Name Telephone

4. _____
Name Telephone

5. _____
Name Telephone

6. _____
Name Telephone

Care Manager/Advocate: Would you trust the above-listed Trustees to hire a Care Manager/Advocate?
If yes, do you have a suggestion as to who the Trustees should hire?

Choice One:_____
Name Telephone

Choice Two:_____
Name Telephone

Choice Three:_____
Name Telephone

PLANNING

TRUST PROVISION CONSIDERATIONS

The special needs person's inheritance will remain in the Special Needs Trust for his/her lifetime unless you provide for circumstances that would allow a full or partial distribution. What circumstances, if any, would you like to trigger a distribution? (For example: If the special needs person has been employed and self-supporting for a designated period of time, such as 24 of the last 28 months.)

What instructions do you have regarding the living situation of the special needs person? (For Example: Is a public facility acceptable? Should he/she be a homeowner someday? Should the caregiver reside with him/her?)

What social opportunities would you like to provide for the special needs person?

Who should receive any remaining funds when the trust terminates? (Please include full legal names.)

If any of the above listed persons have special needs of their own, please explain:

FUNERAL CONSIDERATIONS

If the special needs person owns a cemetery lot or has pre-paid funeral or burial expenses, please describe: