SERVING FAMILIES IN GEORGIA AND TENNESSEE
ELDER LAW
PRACTICE OF DAVID L. MCGUFFEY
Connecting Health, Wealth and Peace of Mind

EIN NO: 55-0819817

David L. McGuffey, CELA*
Elder Law | Special Needs Law | Estate Planning
**Certified Elder Law Attorney by the National Elder Law Foundation*

Please return this form to david@mcguffey.net, or mail it to P.O. Box 2023, Dalton, Georgia 30722.

SPECIAL NEEDS TRUSTS QUESTIONNAIRE

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. If there are sections you don't know the answers to, leave them for when we meet to discuss this form. There are other questions we will ask, but this will get us started.

Date:_____

Are you planning with the disabled person's money or someone else's money (e.g., planning a gift or inheritance)

☐ Disabled person's money ☐ Someone else's money

A. DISABLED PERSON

Full Name: _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Birth Date _____ Social Security No. _____

Medicaid No. _____ Medicare Claim No. _____

Gender: ☐ Male ☐ Female

Disabled Person Suffers from:

❑ Asperger Syndrome ❑ Fragile X Syndrome

- ❑ Attention Deficit Disorder (ADD)
- ❑ Autism
- ❑ Bi-Polar Disorder
- ❑ Blindness
- ❑ Borderline Personality Disorder
- ❑ Brain Injury
- ❑ Cerebral Palsy
- ❑ Deafness
- ❑ Depression
- ❑ Developmentally Delayed
- ❑ Dissociative Disorder
- ❑ Down Syndrome
- ❑ Epilepsy
- ❑ Mental Illness
- ❑ Mental Retardation
- ❑ Obsessive Compulsive Disorder
- ❑ Paraplegia
- ❑ Quadraplegia
- ❑ Rett Syndrome
- ❑ Schizoaffective Disorder
- ❑ Schizophrenia
- ❑ Spina BiFida
- ❑ Tourettes Syndrome
- ❑ Traumatic Brain Injury
- ❑ Other: _____

Prognosis _____

Disabled Person Receives:

- ❑ SSI and Medicaid
- ❑ SSD and Medicare
- ❑ SSI Only
- ❑ Medicaid Waiver
- ❑ Section 8 Housing
- ❑ DDD

- ❑ Group Home
- ❑ Psychiatric Institutionalization
- ❑ Other Public Benefits _____

If disabled person is not receiving any of these benefits, did they apply for them?

- ❑ SSI Date of Filing: _____
- ❑ SSD Date of Filing: _____

Has there been a determination of disability by the Social Security Administration?

- ❑ Yes No

Psychiatric Institution ☐ N/A ☐ _____

- ❑ Other Public Benefits _____

B. MISCELLANEOUS DATA

1. **Living Arrangement** .

Disabled person is living: ☐ At home ☐ In an institution

If in an institution, please list:

Name of Institution _____

Street Address _____

City_____ State_____ Zip _____

Telephone No. _____ Fax No. _____

E-mail address _____

Name of Contact Person at Institution _____

Citizenship .

Disabled person is: ☐ U.S. Citizen ☐ Qualified Alien ☐ Don't Know

2. **Competency** .

Disabled Person is:

- ❑ A competent Adult
- ❑ An incompetent Adult
- ❑ A minor expected to be **competent** at majority
- ❑ A minor expected to be **incompetent** at majority

Does the disabled person have any unmet needs that you are aware of?

_____

_____

_____

3. **Social Security** .

Provide address of Social Security office with which disabled person has contact:

Street Address _____

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

Name of Claims Representative _____

Disabled Person's Parents .

What is the marital status of the disabled person's parents (if the disabled person is living with either of them)?

- ❑ Married
- ❑ Single
- ❑ Widowed
- ❑ Divorced

4. **Father**:

Full Name: _____

Street Address _____

City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____

If father will sign trust, it will be signed in: State_____

5. **Mother**:

Full Name: _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____

If mother will sign trust, it will be signed in: State_____

6. **Guardianship** .

Is the disabled person the subject of a guardianship? □ Yes □ No

If yes, please identify the Guardian and any co-Guardian:

Full Name: _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____

Full Name: _____
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
E-mail address _____ Cell No. _____

Please attach court orders, guardianship letters and related pleadings.

If the disabled person is incompetent and is not subject to a guardianship, is a guardianship required? □ Yes □ No

7. **Disabled Person's Family** .

Disabled person is: □ Married □ Single

If married, Name of Disabled Person's Spouse _____

Name of Child _____ Age of Child _____
Is this child a stepchild? ❑ Yes ❑ No

Name of Child _____ Age of Child _____
Is this child a stepchild? ❑ Yes ❑ No

Name of Child _____ Age of Child _____
Is this child a stepchild? ❑ Yes ❑ No

Name of Child _____ Age of Child _____
Is this child a stepchild? ❑ Yes ❑ No

Name of Child _____ Age of Child _____
Is this child a stepchild? ❑ Yes ❑ No

C. TRUST INFORMATION

1. **Trustee**

Name of Initial Trustee _____

Street Address _____

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

Contact Person (if corporate trustee) _____

Trustee will sign the acceptance of the Trust document in: State _____
County _____

If the trustee is an individual, is he/she bondable? □ Yes □ No

2. **Name of Successor Trustee** _____

Street Address _____

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____
E-mail Address _____ Cell No. _____

Contact Person (if corporate trustee) _____

3. **Trust Funding**

How will Trust be funded?_____

4. **Distribution on Death of Disabled Person**

After the required Medicaid payback, any remaining trust assets are to be distributed to:

□ Spouse
□ Children equally
□ Children unequally
How will distribution be made? _____

□ Other: _____

D. ESTATE PLANNING DOCUMENTS

1. Disabled Person

If the disabled person is competent, he/she has a:

- ❑ Will
- ❑ Health Care POA/Living Will
- ❑ Power of Attorney
- ❑ Banking Power of Attorney

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

- ❑ Yes No

2. Disabled Person's Family

Family members:

- ❑ Will
- ❑ Health Care POA/Living Will
- ❑ Power of Attorney
- ❑ Banking Power of Attorney

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

- ❑ Yes No

If there is anything else you are concerned about, please bring it to our attention.

I have reviewed the information contained in this questionnaire and verify that it is complete, accurate and correct to the best of my knowledge.

_____
Signature of person completing form