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SPECIAL NEEDS TRUST INTAKE FORM

Date: _____

PERSONAL INFORMATION

This form is extremely important. Your accuracy and completeness in responding will help me best represent you.

A. PERSONS WITH DISABILITY (Client)

Client's Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Fax Number: _____

E-mail address: _____ Cell Number: _____

Birth Date: _____ Social Security Number: _____

Gender: Male Female (check one)

Name of Spouse: _____

Client Receives: SSI Medicaid SSD Medicare
 Section 8 Housing Other No Public Benefits

Has Client filed for Social Security Disability? Yes No

If Yes, date of filing: _____

If involved in an injury related litigation, is Client likely to be eligible for Medicare within 30 months of settlement? Yes No

Is Client eligible for Medicare? Yes No

If Yes, date of Medicare eligibility: _____

Has Client filed for any public benefits? Yes No

If Yes, please describe: _____

continued

Does the client have private health insurance? Yes No

If so, is it through his or her employment? Yes No

Please provide name of insurer: _____

What is the major medical maximum under the policy? _____

If known, please provide the monthly premium amount: _____

B. FAMILY

I. Client's Children (if applicable):

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

Are any of your children blind, disabled, or receiving SSI or another form of government entitlement?

Yes No If Yes, please explain below:

2. Client's parents (complete only if parents will be establishing the trust or serving as trustee):

Father: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-mail address: _____ Cell Number: _____

continued

U.S. Citizen? Yes No

If father will sign trust as grantor, it will be signed in: State: _____

County _____

Mother: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-mail address: _____ Cell Number: _____

U.S. Citizen? Yes No

If father will sign trust as grantor, it will be signed in: State: _____

County _____

C. MISCELLANEOUS DATA

1. Is the Client living at home or in an institution? Home Institution

If in an institution, please list:

Name of Institution: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-mail address: _____ Cell Number: _____

2. Is the Client a U.S. citizen? Yes No

3. If the Client is not a U.S. citizen, is he/she a qualified alien? Yes No Don't Know

4. Is the Client an adult? Yes No

If yes, is the Client: Competent Incompetent

If no, is the Client: A minor expected to be competent at majority

A minor expected to be incompetent at majority

continued

5. Address of Social Security office with which Client has contact:

Street Address: _____

City: _____ State: _____ Zip Code: _____

6. Is the Client the subject of a guardianship? Yes No

Name of Guardian: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-mail address: _____ Cell Number: _____

Name of Co-Guardian (if applicable): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

E-mail address: _____ Cell Number: _____

Please attach court orders, guardianship letters and related pleadings.

7. If the Client is incompetent and is not subject to a guardianship, is a guardianship required?

Yes No

NOTE: If Yes, complete Guardianship Intake Forms.

D. ESTATE PLANNING DOCUMENTS

I. If the client is competent, does he or she have a:

- Will
- Living Will
- Health Care Power of Attorney
- Financial Power of Attorney

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

Yes No

continued

2. Do the family members have:

- Will
- Living Will
- Health Care Power of Attorney
- Financial Power of Attorney

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

Yes No

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(s) _____

*Thank you for selecting McGuire, Wood & Bisette, PA for your family's legal needs.
We appreciate your letting us know how you came to select our firm.*

HOW DID YOU SELECT OUR FIRM?

- Advertisement
- Website
- Article
- Yellow Book
- Yellow Pages
- Attorney: Name/Address/Phone:

- Other Person: Name/Address/Phone:

- Client: Name/Address/Phone:

Notes/Comments: _____
