

Special Needs Planning Questionnaire (Single Person)

Date: _____

Person supplying answers to these questions: Client Parent Other (Relationship: _____)

If other than Client: Name _____

Address _____

Phone--Day: _____ Night: _____ Mobile: _____

Fax: _____ Email: _____

Full Name of Person with Disability

Date of Birth:

Social Security No.:

Home Address:

Email:

Fax:

Phone (Home):

Phone (Mobile):

County:

Phone (Work):

Mailing address (if different from above):

Living Arrangements:

Owner Occupied

Rented Home or Apartment

With Relatives: _____

Group Home or ICF-IID Facility: _____

Assisted Living Facility: _____

Nursing Home: _____

Who else lives there (if not institution):

Citizenship: U.S. Resident Alien Neither

Your Health
("You" refers to person with disability)

Diagnoses: _____

Medication(s): _____

Nursing help you are getting now: _____

Activities you need help with (check all that apply):

Dressing Bathing Toileting Transferring Eating Taking Medication

Known limitations on life expectancy?

Yes No If Yes, please explain: _____

Mental status (check all that apply, when you are at your best):

Recognize friends & family: Yes No Sometimes

Can describe own money & property: Yes No Sometimes

Can name all close family members: Yes No Sometimes

Comments: _____

Nursing Home/Hospital Information (if applicable)

Please include all nursing homes, hospitals and rehabilitation facilities utilized for the same spell of illness or injury as that currently in treatment (if any)

| Date In | Date Out | Name of Facility (& place if not Austin) | NH | Hosp | Rehab |
|---------|----------|--|----|------|-------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

If you are in a nursing home now--Is Medicare paying for your nursing home stay now?

Yes No

| Anticipated Future Need for Long Term Care | Life Expectancy |
|---|--|
| Hospital: <input type="checkbox"/> > 6 mos. <input type="checkbox"/> 1-6 ms. <input type="checkbox"/> <1 mo. | <input type="checkbox"/> No known limit |
| Nursing Home: <input type="checkbox"/> > 6 mos. <input type="checkbox"/> 1-6 ms. <input type="checkbox"/> <1 mo. | <input type="checkbox"/> Less than 6 months according to Dr. |
| Assisted Living: <input type="checkbox"/> > 6 mos. <input type="checkbox"/> 1-6 ms. <input type="checkbox"/> <1 mo. | <input type="checkbox"/> Uncertain whether limited |
| Home Care: <input type="checkbox"/> > 6 mos. <input type="checkbox"/> 1-6 ms. <input type="checkbox"/> <1 mo. | <input type="checkbox"/> Other: |

Your Medical Expenses

| Medical Expense | Cost/Month |
|--|-------------------|
| Nursing Home or Assisted Living Facility (if any) | |
| Medications out-of-pocket | |
| <input type="checkbox"/> Medicare Part A Premium <input type="checkbox"/> Medicare Part B Premium <input type="checkbox"/> Medicare Part D Premium | |
| <input type="checkbox"/> Medicare Supplement Insurance (or HMO) Company: | |
| <input type="checkbox"/> Other Medical Insurance Type: _____ Company: | |
| <input type="checkbox"/> Long Term Care Insurance | |
| Other Medical Expenses | |

Your Family

Do you (or either of you) have one or more living children? Yes No

Do you have any grandchildren who are children of a deceased child of yours? Yes No

Do you know of person with a disability to whom you might consider making gifts? Yes No

If so, name: _____ Relationship if any: _____

List below your children. If a child of yours has died, also list his or her children (your grandchildren):

| Name | Address | Phone | Disabled? ² | Age |
|---|---------|-------|---|-----|
| Married? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain | |
| Married? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain | |
| Married? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain | |

Who now is providing significant assistance to you? Nobody Name(s) _____

Attorney use only:

Notes re family and other sources of support, conflict or difficulty

² A person is "disabled" for this purpose if he or she is unable, due to physical or mental disability, to engage in substantial gainful employment that exists in significant numbers in the national economy. If the person is presently receiving Social Security Disability, Supplemental Security Income (SSI), or Medicaid assistance for long term care, he or she does meet this requirement.

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Also available as part of the eCourse

[2021 Special Needs Trusts eConference](#)

First appeared as part of the conference materials for the
17th Annual Changes and Trends Affecting Special Needs Trusts session
"Masters of SNT—What I Know Now That I Wish I Had Known Back Then"