Clear Form

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: ☐> 6 mos. ☐1-6 ms. ☐ <1 mo.	☐ No known limit
Nursing Home: ☐> 6 mos. ☐1-6 ms. ☐ <1 mo.	☐ Less than 6 months according to Dr.
Assisted Living: ☐> 6 mos. ☐1-6 ms. ☐ <1 mo.	☐ Uncertain whether limited
Home Care: ☐> 6 mos. ☐1-6 ms. ☐ <1 mo.	☐ Other:_____

Your Medical Expenses

Medical Expense	**Cost/Month**
Nursing Home or Assisted Living Facility (if any)	
Medications out-of-pocket	
☐ Medicare Part A Premium ☐ Medicare Part B Premium ☐ Medicare Part D Premium	
☐ Medicare Supplement Insurance (or HMO) Company:	
☐ Other Medical Insurance Type:_____ Company:	
☐ 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? ☐Yes ☐No			☐Yes ☐No ☐Uncertain	
Married? ☐Yes ☐No			☐Yes ☐No ☐Uncertain	
Married? ☐Yes ☐No			☐Yes ☐No ☐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.

Title search: Special Needs Planning questionnaire

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"