

## 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***

| <b>Medical Expense</b>   | <b>Cost/Month</b> |
|--|-------------------|
| Nursing Home or Assisted Living Facility (if any)  |                   |
| Medications out-of-pocket  |                   |
| <input type="checkbox"/> Medicare Part A Premium<br><input type="checkbox"/> Medicare Part B Premium<br><input type="checkbox"/> Medicare Part D Premium |                   |
| <input type="checkbox"/> Medicare Supplement Insurance (or HMO)<br>Company:  |                   |
| <input type="checkbox"/> Other Medical Insurance<br>Type: _____<br>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? <sup>2</sup>  | Age |
|---|---------|-------|---|-----|
| Married? <input type="checkbox"/> Yes <input type="checkbox"/> No |         |       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |     |
| Married? <input type="checkbox"/> Yes <input type="checkbox"/> No |         |       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Uncertain |     |
| Married? <input type="checkbox"/> Yes <input type="checkbox"/> No |         |       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><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

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<sup>2</sup> 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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Title search: Special Needs Planning questionnaire

Also available as part of the eCourse

[Answer Bar: Considering a Special Needs Trust](#)

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