

## 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 <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? <sup>2</sup>	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

---



---



---



---

<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.

Find the full text of this and thousands of other resources from leading experts in dozens of legal practice areas in the [UT Law CLE eLibrary \(utcle.org/elibrary\)](http://utcle.org/elibrary)

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"