

**SELF-SETTLED SPECIAL NEEDS TRUSTS  
QUESTIONNAIRE - ADDITIONAL INFORMATION**

Client Name \_\_\_\_\_ File Number \_\_\_\_\_ Date \_\_\_\_\_

**A. MISCELLANEOUS DATA**

**1. Living Arrangement.**

Disabled person is living:                       At home                       In an institution

If in an institution, please list:

Name of Institution \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail address \_\_\_\_\_

Name of Contact Person at Institution \_\_\_\_\_

**2. Competency.**

Disabled Person is:                       A competent Adult  
    An incompetent Adult  
    A minor expected to be **competent** at majority  
    A minor expected to be **incompetent** at majority

**3. Social Security.**

Provide address of Social Security office with which disabled person has contact:

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Name of Claims Representative \_\_\_\_\_

**4. Disabled Person's Parents.**

What is the marital status of the disabled person's parents (if the disabled person is living with either of them)?

- Married
- Single
- Widowed
- Divorced

**Name of Father** \_\_\_\_\_

Street Address \_\_\_\_\_

(if different from disabled person)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell No. \_\_\_\_\_

U.S. Citizen?       Yes       No

If no, explain under what legal right the father is in this country.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

County \_\_\_\_\_

**Name of Mother** \_\_\_\_\_

Street Address \_\_\_\_\_

(if different from disabled person)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell No. \_\_\_\_\_

U.S. Citizen?       Yes       No

If no, explain under what legal right the mother is in this country.

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If mother will sign trust as grantor, it will be signed in: State \_\_\_\_\_  
County \_\_\_\_\_

**5. Guardianship.**

Is the disabled person the subject of a guardianship?  Yes  No

If yes, please provide the following:

**Name of Guardian** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell No. \_\_\_\_\_

**Name of Co-Guardian** (if applicable) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell No. \_\_\_\_\_

Please attach court orders, guardianship letters and related pleadings.

If the disabled person is incompetent and is not subject to a guardianship, is a guardianship required?  Yes  No

**NOTE: If yes, complete guardianship intake forms.**

**6. Disabled Person's Family.**

Disabled person is:             Married             Single

If married, Name of Disabled Person's Spouse \_\_\_\_\_

**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

**B. TRUST FUNDING**

How will Trust be funded?

With funds Paid by:     Order of the Court  
                                   Order of the Superior Court  
                                   Grantor

Trust funded with:     the sum of \$ \_\_\_\_\_

a structured settlement consisting of an annuity  
(obtain copy of annuity)

Name of Insurance Company \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell No. \_\_\_\_\_

Annuity Contract No. \_\_\_\_\_

**C. DISTRIBUTION ON DEATH OF DISABLED PERSON.**

After the required Medicaid payback, any remaining trust assets are to be distributed to:

- Spouse
- Children equally
- Children unequally

How will distribution be made? \_\_\_\_\_

\_\_\_\_\_

Power of Appointment

Other: \_\_\_\_\_

\_\_\_\_\_