

**Third Party Trust System
Intake Form
(SINGLE)**

Date _____ File Number _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-mail address _____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.

A. PERSONAL DATA

Full Name _____
(print name as shown on your checks)

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security No. _____

U.S. Citizen? Yes No Annual Income _____

If widowed, please list date of death of spouse _____

Will you be establishing the Special Needs Trust? Yes No

Your relationship to the Beneficiary of the Special Needs Trust:

- Father
- Mother
- Brother
- Sister
- Aunt
- Uncle
- Grandfather
- Grandmother
- Other _____

Have you visited our Website at www.begleylawyer.com? Yes No

Do you have any ideas for improving our Website? If so, please discuss.

Have you visited the website of the Special Needs Alliance at www.specialneedsalliance.com?

Yes No

Do you have any ideas for improving that Website? If so, please discuss.

B. DISABLED CHILD

1. Full Name: _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Birth Date _____ Social Security No. _____

Nickname _____ Medicaid No. _____

Gender: Male Female

Select one: Natural child Adopted child Stepchild Child born out of wedlock

The Disabled Person's diagnosis is:

- | | |
|--|--|
| <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Fragile X Syndrome |
| <input type="checkbox"/> Attention Deficit Disorder (ADD) | <input type="checkbox"/> Hearing Impairments/Deafness |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Borderline Personality Disorder | <input type="checkbox"/> Paraplegia |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Quadriplegia |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Rett's Disorder |
| <input type="checkbox"/> Childhood Disintegrative Disorder | <input type="checkbox"/> Schizoaffective Disorder |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Spina BiFida |
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Tourettes Syndrome |
| <input type="checkbox"/> Dissociative Disorder | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other: _____ |

Disabled Person's Prognosis _____

Disabled Persons' Spouse's Name _____

2. Is the Disabled Person Receiving Public Benefits? Yes No

Is the Disabled Person likely to apply for Public Benefits? Yes No

The public benefits the Disabled Person is Receiving or is likely to apply for are:

- SSI
- Medicaid
- SSD
- Medicare
- Medicaid Waiver
- Section 8 Housing
- NJ DDD Benefits
- Group Home
- Psychiatric Institutionalization
- Other Public Benefits _____

If the Disabled Person is not yet receiving public benefits, has there been a determination of disability by the Social Security Administration? Yes No

3. Are the assets to fund the trust the assets of the parent or other third party? Yes No

4. Trustee will be a: Family member Professional Trustee

Is the family member bondable? Yes No

C. ESTATE PLANNING DOCUMENTS

1. The disabled person has a: Will
 Trust
 Living Will
 Health Care Power of Attorney
 Financial Power of Attorney

Would you like intake forms sent to you so that these documents can be prepared if the disabled person is competent? Yes No

Fee: \$ _____

2. Non-parent family members have: Will(s)
 Revocable Living Trust(s)
 Living Will(s)
 Health Care Power(s) of Attorney
 Financial Power(s) of Attorney
 Third Party Special Needs Trust

Would you like intake forms sent to you so that these documents can be prepared?
 Yes No

Fee: \$ _____

D. CLIENT'S NON-DISABLED CHILDREN

Full Name of Child _____ **Gender:** M F

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

Cell Phone No. _____ Email Address _____

Birth Date _____ Social Security No. _____

Select one: Natural child Adopted child Stepchild Child born out of wedlock

Full Name of Child _____ Gender: M F
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
Cell Phone No. _____ Email Address _____
Birth Date _____ Social Security No. _____
Select one: Natural child Adopted child Stepchild Child born out of wedlock

Full Name of Child _____ Gender: M F
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
Cell Phone No. _____ Email Address _____
Birth Date _____ Social Security No. _____
Select one: Natural child Adopted child Stepchild Child born out of wedlock

Full Name of Child _____ Gender: M F
Street Address _____
City _____ State _____ Zip _____
Home Phone No. _____ Fax No. _____
Cell Phone No. _____ Email Address _____
Birth Date _____ Social Security No. _____
Select one: Natural child Adopted child Stepchild Child born out of wedlock

E. CLIENT'S NON-DISABLED GRANDCHILDREN

Full Name of Grandchild _____ Gender: M F

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

Cell Phone No. _____ Email Address _____

Birth Date _____ Social Security No. _____

Select one: Natural grandchild Adopted grandchild
 Stepgrandchild Grandchild born out of wedlock

Full Name of Grandchild _____ Gender: M F

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

Cell Phone No. _____ Email Address _____

Birth Date _____ Social Security No. _____

Select one: Natural grandchild Adopted grandchild
 Stepgrandchild Grandchild born out of wedlock

Full Name of Grandchild _____ Gender: M F

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

Cell Phone No. _____ Email Address _____

Birth Date _____ Social Security No. _____

Select one: Natural grandchild Adopted grandchild
 Stepgrandchild Grandchild born out of wedlock

Full Name of Grandchild _____ Gender: M F

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

Cell Phone No. _____ Email Address _____

Birth Date _____ Social Security No. _____

Select one: Natural grandchild Adopted grandchild
 Stepgrandchild Grandchild born out of wedlock

Do any of your family members have any problems with:

Aids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Addiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spendthrift?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

F. DISPOSITIVE INTENTIONS

1. CHILDREN

If you have children, do you wish to treat all of your children equally? Yes No

If not, why not? _____

After your death, at what age do you want distribution to your children? _____
(e.g. a typical plan provides for 1/2 at age 30 and 1/2 at age 35 or immediate)

Do you want your disabled child's share to go to a Special Needs Trust? Yes No

You want to fund the trust with:

A percentage of your estate – Percentage: _____%

Life insurance

Do you have an existing life insurance policy to fund the trust? Yes No

Specific dollar amount - \$ _____

2. GRANDCHILDREN

If you have grandchildren, do you wish to leave a specific amount of money or a percentage of your estate to your grandchildren? Yes No

Do you wish to treat all of your grandchildren equally? Yes No

If not, why not? _____

How much do you want to leave your grandchildren? _____

At what age do you want distributions to your grandchildren? _____
(e.g., a typical plan provides for 1/2 at age 30, 1/2 at age 35 or immediate)

3. CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? Yes No

If yes, please list:

Name of Charity	Address of Charity	Dollar Amount

4. OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than children, grandchildren or a charity?
 Yes No

If yes, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

G. EXECUTOR

Whom do you wish to serve as your Executor?

First Choice _____

Complete the following only if the Executor is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Second Choice _____

Complete the following only if the Executor is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

H. TRUSTEE

Whom do you want to serve as your Trustee?

First Choice _____

Complete the following only if the Trustee is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Is the Trustee bondable? Yes No

Second Choice _____

Complete the following only if the Trustee is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Is the Trustee bondable? Yes No

Do you want a separate Trustee for the Special Needs Trust? Yes No

If yes:

First Choice _____

Complete the following only if the Trustee is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Is the Trustee bondable? Yes No

Second Choice _____

Complete the following only if the Trustee is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Is the Trustee bondable? Yes No

I. GUARDIAN

If you have minor or disabled child/children, whom do you want to act as Guardian?

First Choice _____

Complete the following only if the Guardian is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

U.S. Citizen? Yes No

Second Choice _____

Complete the following only if the Guardian is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

U.S. Citizen? Yes No

J. LIVING WILL

Do you want your Living Will to provide for withdrawal of artificial food and fluid? Yes No

Do you want to donate your eyes or organs? Yes No

Do you want your Health Care Agent to consult with any other person prior to acting? Yes No

If yes, with whom?

Name of Proposed Health Care Agent _____

Complete the following only if the Health Care Agent is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Name of Proposed Alternate Health Care Agent _____

Complete the following only if the Health Care Agent is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

What are the name and address of your primary care physician?

Full Name of Physician _____

Street Address _____

City _____ State _____ Zip _____

K. POWER OF ATTORNEY

Name of Proposed Financial Agent _____

Complete the following only if the Financial Agent is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

Name of Proposed Alternate Financial Agent _____

Complete the following only if the Financial Agent is not a child named above:

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Fax No. _____

E-mail address _____ Cell No. _____

L. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes No

If yes, please explain

What is the location of your important papers? _____

Do you have a Safe Deposit Box? Yes No

If yes, please indicate the name and address of the location _____

Have you ever made gifts to any one person in excess of \$11,000 in any one calendar year?

Yes No

Have you ever filed a Federal Gift Tax Return? Yes No

M. REFERRAL

By Whom Were You Referred To This Office?

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Telephone No. _____ Fax No. _____

E-mail Address _____ Cell No. _____

Referral is a:

- Attorney
- Trust Company
- Disability Organization

- Insurance Broker
- Financial Advisor
- Other _____