

**Supplemental Needs Trust  
Intake Form: Personal Information**

Date\_\_\_\_\_ File Number\_\_\_\_\_

This form is extremely important. Your accuracy and completeness in responding will help me best represent you.

**A. DISABLED PERSON**

Full Name:\_\_\_\_\_

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

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

Home Phone No.\_\_\_\_\_ Fax No.\_\_\_\_\_

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

Birth Date\_\_\_\_\_ Social Security No.\_\_\_\_\_

Gender:      Male      Female

Spouse's Name\_\_\_\_\_

Disabled Person Receives:    SSI        Medicaid    SSD        Medicare  
                                   Section 8 Housing    Other\_\_\_\_\_

No Public Benefits

Has Disabled Person filed for Social Security Disability?    Yes        No

    If yes, date of filing:\_\_\_\_\_

Is Disabled Person likely to be eligible for Medicare within 30 months of the settlement?  
   Yes        No

Is Disabled Person eligible for Medicare?                    Yes        No

    If yes, date of Medicare eligibility:\_\_\_\_\_

Has Disabled Person filed for any public benefits?    Yes        No

    If yes, please describe:\_\_\_\_\_

**B. FAMILY**

1.     Disabled Person's Children (if applicable):

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

Additional names below or on back

Are any of your children blind, disabled, or receiving SSI or another form of government entitlement?  Yes  No

If yes, please explain below or on back.

2. Disabled Person's Siblings (if applicable):

Name of Sibling \_\_\_\_\_ Phone/E-mail \_\_\_\_\_

Address \_\_\_\_\_

Name of Sibling \_\_\_\_\_ Phone/E-mail \_\_\_\_\_

Address \_\_\_\_\_

Name of Sibling \_\_\_\_\_ Phone/E-mail \_\_\_\_\_

Address \_\_\_\_\_

Additional names below or on back.

Are any of your siblings blind, disabled, or receiving SSI or another form of government entitlement?  Yes  No If yes, please explain below or on back.

3. Disabled Person's parents:

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

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

**C. MISCELLANEOUS DATA**

1. Is the disabled person living at home or in an institution?  Home  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. Is the disabled person a U.S. citizen?       Yes       No
3. If the disabled person is not a U.S. citizen, is he/she a qualified alien?  
 Yes       No       Don't Know

4. Is the disabled person an adult?       Yes       No  
If yes, is the disabled person:  Competent  Incompetent

If no, is the disabled person:

- A minor expected to be competent at majority  
 A minor expected to be incompetent at majority

5. Address of Social Security office with which disabled person has contact:

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

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

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

6. 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.

7. 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.

**D. ESTATE PLANNING DOCUMENTS**

1. If the disabled person is competent, does he or she have a:

- Will
- 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?

- Yes  No

2. Do the family members have:

- Will
- Living Will
- Health Care Power of Attorney
- Financial Power of Attorney
- Third Party Special Needs Trust

Would you like intake forms sent to you so that these documents can be prepared?

- Yes  No

**E. 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:  Claimant's Attorney  Insurance Company  
 Trust Company  Other \_\_\_\_\_

Additional names, addresses, or information:

I have reviewed the information contained in this questionnaire and verify that it is complete, accurate and correct to the best of my knowledge.

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Signature(s)

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