# 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:

| **Name of Person with Disability**<br>(First, Middle & Last) | |
|---|---|
| **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**<br>☐ Own Home<br>☐ Rent-House/Apt.<br>☐ Rent-Assisted Living<br>☐ No Rent-Home of ____________________<br>☐ Nursing Facility _____________________<br>___________________________________<br>**Who else lives there(if not Nursing Home or ALF)** | **Marital History**<br>☐ Never married<br>☐ Previously married --<br>Name of most recent spouse ___________________<br>Date of Marriage ______________________<br>Marriage ended in<br>☐ Divorce Date _______County ______________<br>☐ Death Date of Death________________ |
| **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, even if only from time to time):**

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: ☐> 6 mos. ☐1-6 ms. ☐ <1 mo. | ☐ No known limit |
| Nursing Home: ☐> 6 mos. ☐1-6 ms. ☐ <1 mo. | ☐ Less than 6 months according to Dr. |
| Assisted Living:☐> 6 mos. ☐1-6 ms. ☐ <1 mo. | ☐ Uncertain whether limited |
| Home Care: ☐> 6 mos. ☐1-6 ms. ☐ <1 mo. | ☐ Other:______________________ |

## *Your Medical Expenses*

| Medical Expense | Cost/Month |
|---|---|
| Nursing Home or Assisted Living Facility (if any) | |
| Medications out-of-pocket | |
| ☐ Medicare Part A Premium<br>☐ Medicare Part B Premium<br>☐ Medicare Part D Premium | |
| ☐ Medicare Supplement Insurance (or HMO)<br>Company: | |
| ☐ Other Medical Insurance<br>Type:____________________________________<br>Company: | |
| ☐ 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?[2] | Age |
|---|---|---|---|---|
| Married? ☐Yes ☐No | | | ☐Yes<br>☐No<br>☐Uncertain | |
| Married? ☐Yes ☐No | | | ☐Yes<br>☐No<br>☐Uncertain | |
| Married? ☐Yes ☐No | | | ☐Yes<br>☐No<br>☐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
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

[2] 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.

***Information Concerning Your Residence, If Owned By You:***
*("You" refers to person with disability)*

**Deed is in the name of**
☐ You alone (100% ownership)
☐ You and ________________________________________________, and you own
_____% of the residence. Relationship, if any, of co-owner(s):_________________________
______________________________________________________________________________

**Estimated fair market value (tax appraised value if known): $**______________________

**Amount owed on the mortgage:** ☐ Nothing (paid off) ☐ Presently owe $________________

**Location**: ________________________________________________________________
**Who lives there now?**
☐You alone
☐You and ________________________________ Relationship:_____________________
☐ Renters paying $______ per month
☐ Persons not paying rent:_____________________Relationship:________________

**Other Information**:_________________________________________________________

***Your Other Assets***

| **Resource Description** | **Value** |
|---|---|
| Most Valuable Vehicle[1]: | |
| Vehicle 2: | |
| Vehicle 3: | |
| Vehicle 4: | |
| Resource Description | |
| Gravesite/Marker(s): (Name of Cemetery) | **Value** |
| Prepaid Funeral Contracts | |
| Household Goods: | |
| | |
| | |
| Checking Accounts (Name(s) of Bank(s) or Credit Union(s)): | |
| | |
| | |
| | |
| | |
| | |

[1] Enter year, make, model for all vehicles. Include any motorcycles, boats, trailers or RVs.

| Savings ***not*** in IRA's (Name(s) of Bank(s) or Credit Union(s)): | **Value** |
|---|---|
| | |
| | |
| CD's ***not*** in IRA's (Name(s) of Bank(s) or Credit Union(s)): | |
| | |
| | |
| | |
| Money Markets ***not*** in IRA's (Name(s) of Bank(s) or Credit Union(s)): | |
| | |
| | |
| | |
| Stocks/Bonds ***not*** in IRA's (Brokerage or Security Name) | |
| | |
| | |
| | |
| Untaxed Retirement Acounts (such as 401K's & IRA's "Qualified" Annuities)<br>Company Name: | |
| | |
| | |
| | |
| Tax-Deferred (Nonqualified) Annuities Company Name: | |
| | |
| | |
| Safe Deposit Box: Who else has access: | |
| Bank Location & Contents: | |
| Patient Trust Fund: | |

| Life Insurance: | | | | | Cash Surrender Value |
|---|---|---|---|---|---|
| Company Name | Policy # | Insured | Owner | Face Value | |
| | | | | | |
| | | | | | |
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| Notes Receivable: | **Value** |
|---|---|
| | |
| Real Estate (Other Than Residence): | |
| | |
| | |

| ☐ Tax-Appraised Value if any or ☐ 40X Avg. Monthly Income | **Value** |
|---|---|
| Gas / Oil / Mineral Rights: | |
| County: | |
| | |
| Other (Describe): | |
| | |
| *Attorney use only:*<br>*Total countable resources:* | |
| **DEBTS:** | |
| Homestead Debt: | |
| Other Secured Debt: | |
| Unsecured Debt: | |
| Unsecured Debt: | |
| *Attorney use only:*<br>*Total debts :* | |
| *Net (after debts) countable resources:* | |

***Income Sources***

***Please indicate <u>monthly</u> income:.***

| **SOURCE** | Amount |
|---|---|
| Earned Income (gross): | |
| Social Security Disability (net) | |
| Social Security Retirement (net) | |
| Social Security Childhood Disability Benefit (net) | |
| Amount Deducted for Medicare Part B | |
| Amount Deducted for Medicare Part D | |
| Supplemental Security Income (SSI) | |
| Temporary Assistance for Needy Families (TANF) | |
| Veteran's Benefits (other than retirement) (net) | |
| Retirement Pension from ☐ Military ☐ OPM ☐ ERS ☐ TRS (gross) | |
| Other Disability or Retirement Pension (Source:________________) (net) | |
| Amount Deducted for Health Insurance (except Medicare B & D) | |
| Amount Deducted for Income Tax | |
| Other Deductions (Purpose:__________________________________) | |
| | |
| *For Attorney Use Only:*<br>*Total countable income:* | |

### *Non-Cash Benefits*

**Check all that apply:**

| |
|---|
| ☐ Medicare |
| ☐ Medicaid (Children's) |
| ☐ Medicaid (With SSI) |
| ☐ Medicaid – Home Care |
| ☐ Medicaid – Nursing Home Care |
| ☐ Medicaid Health Insurance Premium Payment (HIPP) |
| ☐ Qualified Medicare Beneficiary (QMB) (Pays Medicare B & Copayments) |
| ☐ Specified Low-Income Medicare Beneficiary (SLMB) (Pays Medicare B) |
| ☐ Qualified Individual – 1 (Pays Medicare B) |
| ☐ Qualified Individual – 2 (Pays Medicare B) |
| ☐ Low-Income Housing |
| ☐ Medicare Part D – Unsubsidized |
| ☐ Medicare Part D - Lower Subsidy ("Extra Help") |
| ☐ Medicare Part D – Higher Subsidy ("Extra Help") |
| ☐ Hospital District Medical Assistance Program:___________________________ |
| ☐ Children's Health Insurance Program (CHIP) |
| ☐ Food Stamps: $______ value per month |
| ☐ Private Health Insurance: |

### *Military Service*

Have you, or a deceased spouse ever been in the armed forces ?☐ YES ☐ NO

| Veteran's Name | Service No. | Relationship | Dates of Service |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Honorable discharge: ☐ YES ☐ NO

## *Other Questions Concerning Your Assets*

**Are you beneficiary of a trust?** ☐Yes ☐No
**Transferred assets to a trust?** ☐Yes ☐No
**Anticipate an inheritance?** ☐Yes ☐No
**Received an inheritance?** ☐Yes ☐No
*(If Yes, be sure anything you still own is listed among your other assets above.)*

**Have you transferred cash or anything worth more than $500 as a gift, or for less than fair market value, in last 5 years?** ☐Yes ☐No

**If Yes, give the following information as to *each* transfer**:

Recipient: ________________________________________________
Asset description (if not cash):_____________________________________
Date:__________ Value of cash or other asset**:$**______________________
Received in return:
☐ Nothing (Gift) ☐$________Cash ☐Other:_______________________worth $__________
Was the transfer motivated, at least in part, by need for SSI or Medicaid eligibility? ☐Yes ☐No
If No, explain purpose(s) of transfer:_________________________________
______________________________________________________________
______________________________________________________________

Recipient: ________________________________________________
Asset description (if not cash):_____________________________________
Date:__________ Value of cash or other asset**:$**______________________
Received in return:
☐ Nothing (Gift) ☐$________Cash ☐Other:_______________________worth $__________
Was the transfer motivated, at least in part, by need for SSI or Medicaid eligibility? ☐Yes ☐No
If No, explain purpose(s) of transfer:_________________________________
______________________________________________________________
______________________________________________________________

Recipient: ________________________________________________
Asset description (if not cash):_____________________________________
Date:__________ Value of cash or other asset**:$**______________________
Received in return:
☐ Nothing (Gift) ☐$________Cash ☐Other:_______________________worth $__________
Was the transfer motivated, at least in part, by need for SSI or Medicaid eligibility? ☐Yes ☐No
If No, explain purpose(s) of transfer:_________________________________
______________________________________________________________
______________________________________________________________

## *Questions concerning legal documents*

| **Document** | Do you have this document? | *Attorney use only: Document Adequate?* |
|---|---|---|
| Will | ☐Yes ☐No ☐Uncertain | ☐Yes ☐No ☐Uncertain |
| Durable Power of Attorney (Financial) | ☐Yes ☐No ☐Uncertain | ☐Yes ☐No ☐Uncertain |
| Power of Attorney for Health Care | ☐Yes ☐No ☐Uncertain | ☐Yes ☐No ☐Uncertain |
| Directive to Physicians (Living Will) | ☐Yes ☐No ☐Uncertain | ☐Yes ☐No ☐Uncertain |
| Special Needs Trust | ☐Yes ☐No ☐Uncertain | ☐Yes ☐No ☐Uncertain |
| Living (Revocable) Trust | ☐Yes ☐No ☐Uncertain | ☐Yes ☐No ☐Uncertain |
| Documents funding Living Trust (deeds, etc.) | ☐Yes ☐No ☐Uncertain | ☐Yes ☐No ☐Uncertain |

| *Attorney use only*-- Notes concerning legal documents: |
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*Attorney use only:*

**Goals of client**:

- ☐ Acquire the best possible long term care, within his/her financial ability
- ☐ Keep in the family certain assets:______________________________________________
- ☐ Acquire effective wills and powers of attorney
- ☐ Protect a child or other person with a disability
- ☐Other:____________________________________________________________________

_____________________________________________________________________________

**Checklist for Plan Preparation:**

**How to obtain documents to copy:**

- ☐Client provided all copies needed
- ☐ We copied all at first conference
- ☐ Return original documents with plan after copying
- ☐ Call ______________________ to pick up documents after copying
- ☐ Have documents hand delivered to __________________________ after copying

**How to deliver plan:**

- ☐ Call ____________________________ to pick up at our office
- ☐ Have plan hand delivered to _________________________
- ☐ Have plan delivered by Fed Ex to ___________________________
- ☐ Mail plan to the following: ________________________________________________
- ☐ Email plan to the following: _______________________________________________