Farrell & Johnson PLLC
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 (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 ☐ Own Home ☐ Rent-House/Apt. ☐ Rent-Assisted Living ☐ No Rent-Home of _____ ☐ Nursing Facility _____ _____ **Who else lives there(if not Nursing Home or ALF)**	**Marital History** ☐ Never married ☐ Previously married -- Name of most recent spouse _____ Date of Marriage _____ Marriage ended in ☐ Divorce Date _____County _____ ☐ 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 ☐ Medicare Part B Premium ☐ Medicare Part D Premium	
☐ Medicare Supplement Insurance (or HMO) Company:	
☐ Other Medical Insurance Type:_____ 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 ☐No ☐Uncertain	
Married? ☐Yes ☐No			☐Yes ☐No ☐Uncertain	
Married? ☐Yes ☐No			☐Yes ☐No ☐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) 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	
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: *Total countable resources:*	
DEBTS:	
Homestead Debt:	
Other Secured Debt:	
Unsecured Debt:	
Unsecured Debt:	
Attorney use only: *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: *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:

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: _____