Farrell & Johnson PLLC
Special Needs Planning Questionnaire (Single Person)

Please do not try to convert this to Word. Open it in Adobe Acrobat and fill in the blanks, or print and complete in ink.

Date:____________

Person supplying answers to these questions: ☐ Client ☐ Parent ☐ Other (Relationship: _________)

If other than Client:Name____

Address____

Phone--Day:__________________ Night:__________________ Mobile:_______________________

Fax: Email:

Full Name of Person with Disability	
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: ☐Owner Occupied ☐Rented Home or Apartment ☐With Relatives:____ ☐Group Home or ICF-IID Facility:____ ☐Assisted Living Facility:____ ☐Nursing Home:____ **Who else lives there (if not institution):**	
Citizenship: ☐U.S. ☐Resident Alien ☐Neither	

Your Health
("You" refers to person with disability)

Diagnoses:____

Medications:

☐Taking medication "as needed" (PRN)

Personal care you are getting now ____

☐Using wheelchair ☐Using walker

☐Sometimes wanders ☐In locked unit or area

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, when you are at your best):

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 Maximim it will pay per month: $_________ Maximum months it will pay: ____________	
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 *or* under age 21 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 ____
Location: ☐ **Address already entered on page 1. If not, street address:**
____

Ownership: ☐ You alone (100% ownership)
☐ You and ____, and you own
______% of the residence. Relationship, if any, of co-owner(s):____________________________
Property tax "fair market value" $______________
Amount owed on the mortgage: ☐ Nothing (paid off) ☐ Presently owe $________________
Monthly payment if any: $_____________________ ☐ Principal & Interest Only ☐ Includes Property Tax & Insurance
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:	
Bank and Credit Union Accounts ***not*** in IRA's or other retirement accounts (Name(s) of Bank or CU and type of account):	

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

	Value
Stocks/Bonds ***not*** in IRA's (Brokerage or Security Name)	
Untaxed Retirement Acounts (such as 401K's & IRA's "Qualified" Annuities) Company Name:	
Nonqualified Annuity Contracts (not in untaxed retirement accounts) Company Name:	
Safe Deposit Box: Who else has access:	
Bank Location & Contents:	
Patient Trust Fund:	

Life Insurance:			
Company Name	Death Benefit	Cash Value	Beneficiary at Death (if any)

Notes Receivable:	**Value**
Real Estate (Other Than Residence):	

Mineral Rights: ☐ Tax-Appraised Value if any or ☐ 40X Avg. Monthly Income County:	
Mineral Rights: ☐ Tax-Appraised Value if any or ☐ 40X Avg. Monthly Income 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:	

Your Income

Please indicate monthly income — ***Monthly Income***

FIXED INCOME	**Amount**
Social Security *Net* Monthly Payment	
Medicare Part B premium deducted	
Medicare Part D premium deducted	
Supplemental Security Income (SSI)	
VA Disability or Pension *Net* Monthly Payment	
Railroad Retirement *Net* Monthly Payment	
Civil Service Annuity *Net* Monthly Payment	
Required Minimum Distributions (average monthly)	
Pension *Net* Monthly Payment	
Annuities *Net* Monthly Payment	
Total of “Possible Deductions” below	
Attorney use only *Total fixed*	
VARIABLE INCOME	
Gross Earned Income	
Interest	
Dividends	

Rental/Notes	
Oil & Gas	
Farm or Other Business Income	
Other Income	
Attorney use only *Total variable*	
Total income	
POSSIBLE DEDUCTIONS	
Tax withheld from pension (monthly)	
Medical ins. premiums withheld from pension (monthly)	
Medical ins. premiums not withheld from pension (monthly)	
Total of Possible Deductions	

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

☐ Medical insurance from employer of ☐ self ☐ other:

Military Service

Have you, a spouse or deceased child(ren) ever been in the U. S. armed forces? ☐ YES ☐ NO
If so, is the veteran deceased, of service related cause(s)? ☐ YES ☐ NO
Does the veteran now have any service-related disability? ☐ YES ☐ NO
If so, is the disability 100%? ☐ YES ☐ NO If so, number of years it has been 100%: _______

Veteran's Name	Service Branch	Dates on Active Duty[1]	Type of Discharge*
			H ☐ G ☐ D ☐
			H ☐ G ☐ D ☐
			H ☐ G ☐ D ☐

** H=Honorable G=General D=Dishonorable*

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:
Have you transferred cash or anything else, for less than fair market value, in last 5 years?
Yes ☐No ☐ If Yes Recipient ___________________________
Asset description ____
Date ___________Value **$**____________________
Received in return ☐ Nothing (Gift) ☐$_________Cash☐Other _____________________________
Was the transfer motivated, at least in part, by need for Medicaid eligibility? ☐Yes ☐No
If No, explain purpose(s) of transfer:____
____

[1] Do not include Active Duty for Training. Do include active duty of a reservist or National Guard member when "called up" (activated).

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
Medical Power of Attorney	☐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
Revocable Living 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:

Your Goals:

☐ 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:

Attorney use only:
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: ____