



## SPECIAL NEEDS INTAKE QUESTIONNAIRE

This form is extremely important. Your accuracy and completeness in responding will help me assist you and the person who is the special needs beneficiary of this planning. Please scan and email me this form in advance of your appointment if possible or bring it to your initial consultation.

Date: \_\_\_\_\_ Person Completing Form: \_\_\_\_\_

### **A. BENEFICIARY**

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

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

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

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

Email Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Medicaid No.: \_\_\_\_\_ Medicare Claim No.: \_\_\_\_\_

Gender: ☐ Male ☐ Female

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

**1. Describe Planning Goals for Beneficiary:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**2. Describe Beneficiary's Current Disability and Level of Care Needed:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Was onset of disability prior to age 22? Prior to age 26? What age? \_\_\_\_\_

• Is Beneficiary competent to handle funds? ☐ Yes ☐ No

• Does Beneficiary require supervision? ☐ Yes ☐ No

• Does Beneficiary have issues with substance abuse? ☐ Yes ☐ No

• Is Beneficiary developmentally disabled? ☐ Yes ☐ No

• Does Beneficiary have an ABLE account? ☐ Yes ☐ No

• Does Beneficiary have a Special Needs Trust? ☐ Yes ☐ No

**3. Prognosis:** \_\_\_\_\_

**4. Where does the Beneficiary live now?**

- ☐ With parents
- ☐ Owns a residence or leases an apartment (with support or independently) living
- ☐ Lives in a residence with a particular person \_\_\_\_\_
- ☐ Group home
- ☐ Private facility
- ☐ Other: \_\_\_\_\_
- Contact Person (if at Facility): \_\_\_\_\_

**5. Citizenship**

Is the Beneficiary:

- ☐ US Citizen      ☐ Qualified Alien      ☐ Don't Know

**6. Competency**

Beneficiary is a:

- ☐ Minor, expected to have full capacity at majority      ☐ Incapacitated adult
- ☐ Minor, expected to be incapacitated at majority      ☐ Competent adult

**7. Public Benefits**

Does Beneficiary receive Medicaid, Medicare, SSDI, SSI, Section 8 housing or other public benefits?  
Describe in detail including amounts received monthly:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**8. Parents**

Name of Parent: \_\_\_\_\_

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

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

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

Email Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

Name of Parent: \_\_\_\_\_

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

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

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

Email Address: \_\_\_\_\_ Cell No.: \_\_\_\_\_

**9. Guardianship:** If the Beneficiary is incapacitated, yet is not subject to a guardianship, do you believe a guardianship required? ☐ Yes ☐ No

If Beneficiary has a Guardian(s), please list the named guardian and provide copy of court orders:

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**10. Estate Planning Documents for Beneficiary (if Beneficiary is an adult)**

If the Beneficiary is competent, does he or she have a:

- ☐ Will
- ☐ Living Will/ Health Care Directive
- ☐ Health Care Power of Attorney
- ☐ Financial Power of Attorney
- ☐ First Party Special Needs Trust

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

☐ Yes ☐ No

**B. ESTATE PLANNING**

Do the family members each have a:

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

If no, would you like our office to send you Questionnaires to you so that these documents can be prepared?

☐ Yes ☐ No

**C. PERSONAL INJURY SUIT INFORMATION (IF APPLICABLE)**

**1. Pending Litigation Information:**

County: \_\_\_\_\_

Case Number: \_\_\_\_\_ Status of Case: \_\_\_\_\_

Other: \_\_\_\_\_

**D. CERTIFICATION**

The undersigned hereby represents to Sara McCulloch Law that the information contained in this questionnaire is accurate and complete, and that the undersigned understands that the lawyer will rely on this information. If the information contained herein is inaccurate or incomplete, the recommendations made by Sara McCulloch Law may not be appropriate.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date