SPECIAL NEEDS BENEFICIARY QUESTIONNAIRE
FOR FIRST PARTY & THIRD PARTY TRUSTS

This form is extremely important. Your accuracy and completeness in responding will help Everist Tillman PLLC represent you. Please bring this completed information packet, including each of the attached schedules, to your initial consultation.

Date: ______________________ File No.: ______________________

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: O Male O Female

Spouse's Name: ______________________

1. Describe Beneficiary's Underlying Disability: ______________________

____

____

2. Describe Beneficiary's Current Disability (therapeutic, educational, vocational and social issues):

____

____

____

- Was onset of disability prior to age 22? O Yes O No
- Is Beneficiary competent to handle funds? O Yes O No
- Does Beneficiary require supervision? O Yes O No
- Does Beneficiary have issues with substance abuse? O Yes O No
- Is Beneficiary developmentally disabled? O Yes O No

424 94th Ave North, St Petersburg, FL 33702 • T: 727-345-5700 • email@everist-tillman.com

3. Prognosis: ____________________

4. Where does the Beneficiary live now?

O With parents

O Owns a residence or leases an apartment (with support or independently) living

O Lives in a residence with a particular person ____________________

O Group home

O Private facility

O Other: ____________________

Contact Person (if at Institution): ____________________

5. Citizenship

Is the Beneficiary:

O US Citizen O Qualified Alien O Don't Know

6. Competency

Beneficiary is a:

O Minor, expected to have full capacity at majority O Incapacitated adult

O Minor, expected to be incapacitated at majority O Competent adult

7. Social Security

Address of Social Security Office with which Beneficiary has contact:

Street Address: ____________________

City: ____________________ State: __________ Zip: ____________________

Telephone No.: ____________________ Fax No.: ____________________

8. Guardianship (if applicable)

Is the Beneficiary the subject of a guardianship? O Yes O No

If yes, please provide the following:

Name of Guardian: ____________________

Street Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Fax No.: ____________________

Email Address: ____________________ Cell No.: ____________________

Name of Co-Guardian (if applicable): ____________________

Street Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Fax No.: ____________________

Email Address: ____________________ Cell No.: ____________________

Please attach court orders, guardianship letters, and related pleadings.

9. **If the Beneficiary is incapacitated, yet is <u>not</u> subject to a guardianship, is a guardianship required?** O Yes O No

   If yes, please complete Guardianship Questionnaire.

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

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

    O Will

    O Living Will

    O Health Care Power of Attorney

    O Financial Power of Attorney

    O First Party Special Needs Trust

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

    O Yes O No

<u>B. ESTATE PLANNING</u>

Do the family members each have a:

O Will

O Living Will

O Health Care Power of Attorney

O Financial Power of Attorney

O 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? O Yes O No

<u>C. PERSONAL INJURY SUIT INFORMATION (IF APPLICABLE)</u>

1. **Pending Litigation Information:**

   County: ______________________________

   Case Number: ______________ Status of Case: ______________

   Other: ______________________________

2. **Attorney**

   Personal Injury Attorney: ______________________________

   Name of Law Firm: ______________________________

   Street Address: ______________________________

   City: ______________ State: ________ Zip: ______________

   Telephone No.: ______________ Fax No.: ______________

   E-Mail Address: ______________ Cell No.: ______________

3. Defense Attorney

Defense Attorney: ______________________________

Name of Law Firm: ______________________________

Street Address: ______________________________

City: ____________________ State: ________ Zip: ____________

Telephone No.: ____________________ Fax No.: ____________________

E-Mail Address: ____________________ Cell No.: ____________________

4. Structured Settlement Broker

Other: ______________________________

D. REFERRAL

Who referred you to our office?

Name: ______________________________

Company Name: ______________________________

Street Address: ______________________________

City: ____________________ State: ____________ Zip: ____________

Phone Number: ____________________ Email Address: ____________________

Have you visited our website at www.Everist-Tillman.com? O Yes O No

Do you have any ideas for improving our website? If so, please discuss: ____________________

E. CERTIFICATION

The undersigned hereby represents to Everist Tillman PLLC that the information contained in this questionnaire (including the attached schedules) is accurate and complete, and that the undersigned understands that the law firm will rely on this information. If the information contained herein is inaccurate or incomplete, the recommendations made by Everist Tillman PLLC may not be appropriate.

______________________________ ______________________________

Signature of Client or Client Representative *Date*

ATTENTION: INSTRUCTIONS FOR SCHEDULES 1 & 2

A **Third Party Supplemental Needs Trust** is established by anyone other than the Special Needs Beneficiary ("Beneficiary") and is funded with resources that are owned by the third party (such as Parents, Siblings, or Grandparents). If you are creating a Third Party Supplemental Needs Trust for a Family Member, please complete **SCHEDULE 1**.

However, if the trust required is to protect funds **owned** by the Special Needs Beneficiary, then complete **SCHEDULE 2** for a **First Party Trust,** also referred to as a **Self-Settled Special Needs Trust**.

SCHEDULE 1: Third Party Supplemental Needs Trust Information

Please note, we will spend time during our first meeting completing this Schedule. However, you may want to review the following list of questions in anticipation of our meeting.

1. Who is establishing the Trust? ______________________________

O Parent(s): ______________________________

O Grandparent(s): ______________________________

O Other: ______________________________

2. Do you want your Trust to be irrevocable or revocable? ______________________________

3. Initial assets to be contributed to the Trust? ______________________________

4. Who will be initial Trustee(s)? ______________________________

O Parent(s): ______________________________

O Corporate Trustee: ______________________________

O Other: ______________________________

5. Who are the Successor Trustees (include a corporate Trustee?) ______________________________

6. Should the Trust require Trustee to post a bond?

____

7. Who should receive the Trust estate when your Beneficiary dies?

O Beneficiary's descendants

O Your descendants

O Other: ______________________________

8. Would you like your Trust to give your Beneficiary a Power of Appointment (i.e., a final say in who receives the Trust assets upon Beneficiary's death?). If yes, would you like the Power to be limited to a certain group of people (ex., siblings), or may the Beneficiary gift the remaining trust assets to any person or entity? ______________________________

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SCHEDULE 1 (continued)

9. What is your hope for the Beneficiary's optimal living arrangement in the future?

O Own a residence or lease an apartment (with support or independently);

O Live in a residence with a particular person: ______________________________

O Group home

O Private facility

O Other: ______________________________

10. Are any of the following unacceptable living arrangements?

O Group Home

O Public Institution

O Public Care Facility

11. Should your Trust include provisions describing the types of social activities that might be important to your Beneficiary? Such as:

O Participation at sporting activities (including Special Olympics)

O Attending sporting events, or cultural events

O Participating in religious activities

O Attending religious services

O Other: ______________________________

12. We recommend the use of a Trust Protector (ability to amend trust and remove Trustee, if necessary). If you agree, how should the Trust Protector be chosen? (Select one)

O Your selection for Trust Protector (if known): ______________________________

O Attorney for Trustee may select later

O The Court shall select upon petition

13. We recommend that your Trust include provisions regarding a Trustee's use of professional services to manage the care of the Beneficiary.

a. If you agree, would you like your Trust to suggest or require the use of professional services?

____

b. If you agree, please indicate your preference for type of professional services you prefer for your Beneficiary:

O Licensed Social Worker   O Care Manager   O Attorney-Advocate

O Advisory Committee   O Non-profit/Agency   O Registered Nurse

O Other: ______________________________

14. We recommend that your Trust include provisions regarding a Trustee's use of an annual care plan to manage the care of the Beneficiary.

a. If you agree, would you like your Trust to suggest or require the use of annual care' plan to manage the care of the Beneficiary?

____

b. Would you like the Trust to require face-to-face periodic assessments? ____________________

c. Would you like the Trust to require visits to the Beneficiary? If yes, what is your preferred schedule?

____

15. Would you like your Trust to include provisions permitting your Trustee to make gift purchases on behalf of your Beneficiary to other family members or friends? If yes, what is maximum value of gift to be given per person and how frequently may gifts be given?____________________

16. Would you like your Trust to include a "relief valve" so that if the Trust is challenged, the Trust can be terminated and distributed to a trusted family member or friend?

If yes, name of trusted person: ____

17. Would you like your Trust to allow early termination if:

O Trust renders Beneficiary ineligible for public benefits

O Beneficiary is substantially gainfully employed on a long-term basis

O None of the above

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SCHEDULE 2: First Party Trust (also referred to as a Self-Settled Special Needs Trust)

Please note, we will spend time during our first meeting completing this Addendum. However, you may want to review the following list of questions in anticipation of our meeting.

1. Who is establishing the Trust?

O Parent(s):____

O Grandparent(s): ____

O Court: ____

O Guardian(s): ____

2. Initial assets to be contributed to the Trust? ____

____

3. Who will be initial Trustee(s):

O Parent(s):____

O Corporate Trustee: ____

O Other: ____

4. Who are the Successor Trustees (include a corporate trustee)? ____

____

5. Who should receive the Trust estate when your Beneficiary dies?

O Beneficiary's descendants

O Your descendants

O Other: ____

6. What is your hope for the Beneficiary's optimal living arrangement in the future?

O Own a residence or lease an apartment (with support or independently);

O Live in a residence with a particular person: ____

O Group home

O Private facility

O Other: ____

SCHEDULE 2 (continued)

7. Are any of the following unacceptable?

O Group Home

O Public Institution

O Public Care Facility

8. Should your Trust include provisions describing the types of social activities that might be important to your Beneficiary? Such as:

O Participation at sporting activities (including Special Olympics)

O Attending sporting events, or cultural events

O Participating in religious activities

O Attending religious services

O Other: ____________________

9. Would you like your Trust to permit early termination of the Trust? If yes, the following reasons are typical provisions:

O Beneficiary is no longer disabled

O Beneficiary eligibility for public benefits is terminated

O Beneficiary is gainfully employed

O Insufficient assets to justify Trust continuation.

Note: The termination of the Trust estate will require an immediate payback to the State for any Medicaid benefits received up to point of termination.

10. Should the Trust require Trustee to post a bond?

____

11. We recommend the use of a Trust Protector (ability to amend trust and remove Trustee, if necessary). If you agree, how should the Trust Protector be chosen? (Select one)

O Your selection for Trust Protector (if known): ____________________

O Attorney for Trustee may select later

O The Court shall select upon petition

SCHEDULE 2 (continued)

12. **We recommend that your Trust include provisions regarding a Trustee's use of professional services to manage the care of the Beneficiary.**

    a. If you agree, would you like your Trust to suggest or require the use of professional services?

    ____

    b. If you agree, please indicate your preference for type of professional services you prefer for your Beneficiary:

    O Licensed Social Worker O Care Manager O Attorney-Advocate

    O Advisory Committee O Non-profit/Agency O Registered Nurse

    O Other: ____

14. **We recommend that your Trust include provisions regarding a Trustee's use of an annual care plan to manage the care of the Beneficiary.**

    a. If you agree, would you like your Trust to suggest or require the use of annual care' plan to manage the care of the Beneficiary?

    ____

    b. Would you like the Trust to require face-to-face periodic assessments? ______________________

    c. Would you like the Trust to require visits to the Beneficiary? If yes, what is your preferred schedule?

    ____

15. **Would you like your Trust to include provisions permitting your Trustee to make gift purchases on behalf of your Beneficiary to other family members or friends? If yes, what is maximum value of gift to be given per person and how frequently may gifts be given?**__________________________

16. **Would you like your Trust to include a "relief valve" so that if the Trust is challenged, the Trust can be terminated and distributed to a trusted family member or friend?**

    If yes, name of trusted person: ____

17. **Would you like your Trust to allow early termination if:**

    O Trust renders Beneficiary ineligible for public benefits

    O Beneficiary is substantially gainfully employed on a long-term basis

    O None of the above