THE LAW OFFICE OF
ANTONY M. EMINOWICZ ESQ
Wills, Trusts and Medicaid Asset Protection

Supplemental Needs Trust Questionnaire

A. PERSONAL DATA

(Self)

Full Name ____

(Print name as shown on your checks)

Street Address ____

City _____________ County: _______________ State ____________ Zip _________________

Home Phone No. _____________________ Business Phone No. _________________________

Cell Phone No. ______________________ Fax No. ___________________________________

E-mail address ____

Birth Date __________________________ Social Security No. _________________________

U.S. Citizen? ❑ Yes ❑ No

Annual Income ___________________________________

Are you married? ❑ Yes ❑ No

Name of Spouse: _________________________________

Do you have a legal guardian? ❑ Yes ❑ No

Are any of your natural or adopted parents living? ❑ Yes ❑ No

Your Medical diagnosis is: ____

Your treating physician: ____

Tel: 845.481.5001
antony@muradlegal.com
Fax: 845.853.1689
www.ame-law.com

Are you employed? ❑ Yes ❑ No

Monthly income from employment: $___________________________

Are you receiving public benefits? ❑ Yes ❑ No

Monthly income from public benefits: $_________________________

The public benefits you are receiving or are likely to apply for are:

❑ SSI ❑ Medicaid ❑ SSD

❑ Medicare ❑ Medicaid Waiver ❑ Section 8 Housing

❑ Group Home ❑ Psychiatric ❑ Institutionalization

❑ Other Public Benefits______________________________________

Is there a case worker involved? ❑ Yes ❑ No

Name and address of caseworker: ____

If you are not receiving public benefits, has there been a determination of disability by the Social Security Administration? ❑ Yes ❑ No

Are the assets to fund the trust are the assets of a parent or other third party? ❑ Yes ❑ No

Trustee will be a: ❑ Family member ❑ Professional trustee

Have you or will you be receiving a settlement from a law suit? ❑ Yes ❑ No

If yes, amount of settlement $__________________________________

Is there legal counsel involved ❑ Yes ❑ No

Name of legal counsel ____

B. <u>ESTATE PLANNING DOCUMENTS</u>

I. The disabled person has a:

❑ Will ❑ Living Will

❑ Health Care Power of Attorney ❑ Financial Power of Attorney

❑ Trust

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2. Non-parent family members have:

❑ Will(s) ❑ Financial Power(s) of Attorney Living Will(s)

❑ Health Care Power(s) of Attorney ❑ Living Will(s)

❑ Third-Party Special Needs Trust ❑ Revocable Living Trust(s)

A. PARENTS

Do you have living parents? ❑ Yes ❑ No

If yes, please check the applicable boxes:

❑ Mother ❑ Father
❑ NY Resident? ❑ Resident?
Age? _______ Age? _______

B. REMAINDFR BENEFICIARIES OF THE TRUST

Full Name ________________________ Gender: ❑ Male ❑ Female

Relationship to Disabled SNT Beneficiary ____

Street Address ____

City _______________________________ State _____________ Zip _______________

Home Phone No. ____________________ Fax No. ____________________________________

E-mail address_______________________ Cell No. ___________________________________

Birth Date __________________________

Full Name __________________________ Gender: ❑ Yes ❑ No

Relationship to Disabled SNT Beneficiary ____

Street Address ____

City ________________________________ State ______________ Zip _______________

Home Phone No. ______________________ Fax No. __________________________________

E-mail address ________________________ Cell No. ___________________________________

Birth Date ____________________________

Full Name ____________________________ Gender: ❑ Yes ❑ No

Relationship to Disabled SNT Beneficiary ____

Street Address ____

City __________________________________ State _______________ Zip ________________

Home Phone No. ________________________ Fax No. ____________________________________

E-mail address __________________________ Cell No. _____________________________________

Birth Date ______________________________

C. CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? ❑ Yes ❑ No

If yes, please list:

Name Of Charity	Address of Charity	Dollar Amount

D. LIFE INSURANCE/LONG TERM CARE INSURANCE

Name of Company _________________________________ Policy# ______________________________

Street Address ____

City _______________________ State _____________________ Zip ____________________________

Type of Policy _______________ Owner ____

Insured ____________________ Beneficiary ____

Death Benefit: $ ____________ Face Value $ _________________ Cash Value $ _________________

Name of Company ______________________________ Policy# ___________________________

Street Address ____

City ____________________ State ___________________ Zip _________________________

Type of Policy _____________ Owner ____

Insured ___________________ Beneficiary ____

Death Benefit: $ ___________ Face Value $ ______________ Cash Value $ _______________

E. POSSIBLE TRUSTEES

Would you consider a corporate or non-profit Trustee? ❑ Yes ❑ No

Potential Individual Trustees:

Full Name __________________________________ Gender: ❑ Male ❑ Female

Relationship to Disabled SNT Beneficiary ____

Street Address ____

City______________________ State ____________________ Zip ________________

Home Phone No. _________________ Fax No. _______________________________________

E-mail address _______________________________ Cell No. _________________________

Birth Date ___________________________________

Full Name __________________________________ Gender: ❑ Male ❑ Female

Relationship to Disabled SNT Beneficiary ____

Street Address ____

City______________________ State ____________________ Zip ________________

Home Phone No. _________________ Fax No. _______________________________________

E-mail address _______________________________ Cell No. _________________________

Birth Date ___________________________________

MISCELLANEOUS

Do you have any other legal issues which I should be aware of? ❑ Yes ❑ No

If yes, please explain

What is the location of your important papers? ____

Do you have a safe deposit box? ❑ Yes ❑ No

If yes, please indicate the name and address of the location ______________________________

____

Have you ever made gifts to any one person in excess of $500 in any one calendar year? ❑ Yes ❑ No

Have you ever filed a federal gift tax return? ❑ Yes ❑ No

F. REFERRAL

By Whom Were You Referred To This Office? ____

Full Name ____

Street Address ____

City ________________________ State ______________________ Zip ______________________

Telephone No. _______________ Fax No. ____

E-mail address _____________________________________Cell No. _________________________

Referral is a: ❑ Attorney ❑ Insurance Broker ❑ Trust Company ❑ Financial Advisor

❑ Disability Organization ❑ Other ____

G. YOUR ADVISORS:

	Name	Telephone No.
Accountant	____________________________	_________________________
Life Insurance Agent	____________________________	_________________________
Investment Advisor	____________________________	_________________________
Other Attorney	____________________________	_________________________
Other Consultant or Advisor	____________________________	_________________________
Physician	____________________________	_________________________
Service Providers	____________________________	_________________________

Assets/Liabilities

Please insert the value of each asset/liability in the appropriate space.

Assets	Self	Jointly Held Funds	Liabilities
Personal Effects/Household items	$		
Automobile	$		
Checking Account	$		
Savings Account	$		
Money Market Account	$		
Certificates of Deposit	$		
Residence (Assessed Value) Block #____ Lot #____ (Obtain from Tax Bill)	$		
Other Real Estate	$		
Additional Automobiles	$		
Mutual Funds	$		
Stocks	$		
Bonds	$		
Annuities	$		
Cash Value--Life Insurance	$		
IRA	$		
Nursing Home Deposit	$		
Other	$		
Other	$		
Total	$		

What did you pay for your current home including any improvements? $ ______________________

Do you own any real property other than personal residence? _______________________________