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

Supplemental Needs Trust Questionnaire

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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.	
Email 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			

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. ESTATE PLANNING DOCUMENTS

I. The disabled person has a:

- ☐ Will
- ☐ Living Will
- ☐ Health Care Power of Attorney
- ☐ Financial Power of Attorney
- ☐ Trust

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)

I. PARENTS

Do you have living parents? Yes ☐ No ☐

If yes, please check the applicable boxes:

Mother	☐	NY Resident?	☐	Age?	
Father	☐	Resident?	☐	Age?	

II. REMAINDER 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: 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

III. 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

IV. 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 $

V. 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 _____

C. MISCELLANEOUS

Would you consider a corporate or non-profit Trustee? 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 ☐

D. REFERRAL

By Whom Were You Referred To This Office?

Full Name

Street Address

City State Zip

Home Phone No. Fax No.

E-mail address Cell No.

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

☐ Disability Organization ☐ Other

E. YOUR ADVISERS:

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

F. 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	$		
Total	$		

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

Do you own any real property other than personal residence?