PIERRO, CONNOR & STRAUSS, LLC
Trusted Counsel

CONFIDENTIAL
SUPPLEMENTAL NEEDS TRUST PLANNING QUESTIONNAIRE

DATE COMPLETED: _____

Name of person completing form: _____

Are you a current client? Yes _____ No _____

If you are completing this form for someone other than yourself and/or your spouse:

Address of person completing form: _____

_____

_____

Relationship to person(s) described below: _____

SECTION 1. PERSONAL INFORMATION

If the individual for whom this is being completed is single, widowed, or an unmarried minor, complete only appropriate sections.

	Father	Mother
Full Name:	_____	_____
Address:	_____	_____
	_____	_____
Home Telephone:	_____	_____
Business Telephone:	_____	_____
Date of Birth:	_____	_____
U.S. Citizen	Yes _____ No _____	Yes _____ No _____
Social Security No.:	_____	_____

CHILDREN, GRANDCHILDREN AND/OR RELATIVES

1. Name: _____Relation: _____

Address: _____

_____ US Citizen: Yes_____ No ____

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

2. Name: _____ Relation: _____

Address: _____

_____ US Citizen: Yes_____ No ____

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

3. Name: _____ Relation: _____

Address: _____

_____ US Citizen: Yes_____ No ____

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

4. Name: _____ Relation: _____

Address: _____

_____ US Citizen: Yes_____ No ____

Tel No.: Home: _____ Wk: _____Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

5. Name: _____ Relation: _____

Address: _____

_____ US Citizen: Yes_____ No ____

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

SECTION 2. DISABILITY

What is the name of the family member with a disability? _____

Describe the nature of the disability:

_____

_____

_____

_____

_____

_____

THE FOLLOWING SECTION REQUESTS INFORMATION CONCERNING THE INDIVIDUAL WITH THE DISABILITY. LATER IN THE QUESTIONNAIRE YOU WILL BE ASKED FOR INFORMATION PERTAINING TO YOU AND OTHER FAMILY MEMBERS.

SECTION 3. INCOME

List below any income that the disabled individual currently receives.

Fixed Monthly:

Wages $ _____
Describe the type and place of employment: _____

_____

Social Security (including SSDI) $ _____
Supplemental Security Income $ _____
Other private or government benefits (describe):

$ _____

$ _____

$ _____

TOTAL INCOME: $ _____

SECTION 4. ASSETS/RESOURCES

Cash, CDs and Bank Balances:

Name of Bank/Branch	Account No.	Type of Account	Balance	How Title Held

Securities (Bonds, Mutual Funds, Marketable Securities, etc.):
(or attach account statement)

Company or Issuer	# of Shs. or Face Value	Approx. Value Per Share	How Title Held

Company or Issuer	# of Shs. or Face Value	Approx. Value Per Share	How Title Held

Other (please explain and provide value of asset):

Is the disabled individual expecting to receive any inheritances or current gifts (eg. From a grandparent, sibling, etc.)? If so, please describe the possible source and expected amount:

SECTION 5. HEALTH AND OTHER INSURANCE

Is the disabled individual covered under a private health insurance policy? Yes _____ No _____

Whose policy? _____

Currently receiving Medicare? Yes _____ No _____

Currently receiving Medicaid? Yes _____ No _____

SECTION 6. RESPONSIBLE PERSONS

Who now has "assistance" responsibilities (i.e., are any family members or other individuals providing any type of care to the individual needing assistance)? If different from person completing this form, please list name, phone number, and relationship to the person providing the care:

_____

_____

_____

SECTION 7. CURRENT CARE PROVIDERS/COUNSELORS

Primary Care Physician:

Physician's Name: _____

Specialty: _____

Address: _____

_____

Business Telephone: _____

Is the individual needing care currently receiving case management services? If so, please provide:

Name of current case manager: _____

Organization: _____

Is the individual needing care currently receiving services through a waiver with the Department of Health of Office of Mental Retardation and Developmental Disabilities?

DOH _____ OMRDD _____

If so, when were wavered services first approved? _____

Describe the services currently being provided under the Waiver:

_____

_____

_____

_____

THIS SECTION REQUESTS INFORMATION ABOUT THE PARENTS/CAREGIVERS OF THE INDIVIDUAL WITH THE DISABILITY

	Father	Mother
Job/Position:	_____	_____
Approximate Annual Income:	_____	_____
Health Problems:	_____	_____
	_____	_____

SECTION 8. PROFESSIONAL ADVISORS

Other Attorney: _____

Tax Advisor: _____

Financial Planner: _____

SECTION 9. ASSETS AND LIABILITIES

Cash, CDs and Bank Balances:

Name of Bank/Branch	Account No.	Type of Account	Balance	How Title Held

Securities (Bonds, Mutual Funds, Marketable Securities, etc.):
(or attach account statement)

Company or Issuer	# of Shs. or Face Value	Approx. Value Per Share	How Title Held

IRA, Keogh, and/or Other Retirement Plans (provide copies of plan documents and beneficiary designations):

Company	Name(s) on Account	Amount	Beneficiary

Life and Accident Insurance & Annuities:

Description (Co. & Type of Contract	Policy No.	Owner	Primary & Contingent Beneficiary	Present Cash Value	Face Amount of Death Benefit

Real Estate: *Please provide us with a copy of the deed and most recent tax bill.*

Description (Location)	Title Held	Cost/Basis	Encumbrances	Market Value

Personal Property:

Do you own any personal property of special value (eg. Antiques, paintings, etc.)? If so, please explain:

Employee Benefits (if you are currently collecting retirement or disability benefits):

To Whom Paid?	Monthly Amount	Beneficiary

Rights or Interests in Trusts, Estates, or Prospective Inheritance (please bring a copy of the instrument, if available):

SECTION 10. PRIOR GIFTS

Have you ever made gifts to any one person in a calendar year between 1932 and 1981 greater than $3,000/year or after 1981 having a value greater than $10,000 or more?

Yes ☐ No ☐

Have you and your spouse jointly made gifts to any one person in a calendar year between 1981 and 2002 having a value greater than $20,000? Yes ☐ No ☐

Have you and your spouse jointly made gifts to any one person in a calendar year between 2002 and 2005 having a value greater than $22,000? Yes ☐ No ☐

Have you and your spouse jointly made gifts to any one person in a calendar year after 2005 having a value greater than $24,000? Yes ☐ No ☐

If so, were gift tax returns filed? Yes ☐ No ☐

Beneficiary	Date of Gift	Amount of Gift

CHECKLIST OF ITEMS TO BRING TO OUR OFFICE

Check if you have any of the following instruments, and provide copies of same.

Father	Mother	
		Prior Will
		Existing Trust documents where you are donor or beneficiary
		Power of Attorney
		Living Will and/or Health Care Proxy
		Life Insurance Policies
		Deeds to Real Property
		Recent Tax Bill associated with Deeds
		Real Property Appraisals, if any
		Prior Gift Tax Returns
		Last Federal Income Tax Return

Qualified Plan/IRA documents, including the following:

		Plan and Amendments
		Summary Plan Description and any material modifications
		Summary Annual Report (SAR)

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