

Special needs estate planning questionnaire

Creating a strategy for the continued care and lifestyle of your family member with special needs allows your love to last beyond your lifetime. The sooner you start preparing, the more confident you may feel in reaching your goals. To help ensure our analysis and recommendations are as accurate as possible, it is crucial you provide all relevant information.

Parent or guardian contact information

First name _____	First name _____
Middle name _____	Middle name _____
Last name _____	Last name _____
Street _____	Street _____
City _____	City _____
Fax _____	Fax _____
State _____ Zip _____	State _____ Zip _____
Age _____	Age _____
Email _____	Email _____
Primary phone _____	Primary phone _____
Employer _____	Employer _____
Occupation _____	Occupation _____
Work phone _____	Work phone _____
Marital status _____	Marital status _____

Do you have any of the following? If so, indicate when the document was last updated:

	Last will and testament	Revocable living trust	Irrevocable trust	Power of Attorney	Health care directives
Last updated	_____	_____	_____	_____	_____

Dependents

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special needs

Name of family member with special needs _____

Tell me more about your child. Likes, dislikes, hobbies, etc. _____

Is he/she employed? Yes No

Employer _____

Estimated annual earnings _____

Does he/she currently receive any of the following?

SSI benefits and type _____ Monthly payment _____

VA or state services _____ Amount _____

Social Security disability benefits _____ Monthly payment _____

Other disability benefits _____ Amount _____

Other unearned income _____ Amount _____

Medical insurance

Is he/she covered by:

Medical insurance? Yes No Will coverage be canceled due to attained age? Yes No

Medicaid? Yes No

Medicare? Yes No

Other government programs? _____

Assets

Are any assets in your loved one's name? Yes No

Asset type	Asset value
_____	_____
_____	_____
_____	_____
_____	_____

Are any assets held by a custodian? Yes No

Name and address of custodian _____

Have you, relatives or friends used any of the following to provide for your loved one with special needs?

- Wills Yes No Unknown
- Trusts Yes No Unknown
- Beneficiary designations, such as life insurance and retirement plans Yes No Unknown
- Other assets that will be transferred upon death Yes No Unknown

List these assets below. Circle any directed to a Special Needs Trust.

Name	Asset to be transferred	Current value	Beneficiary
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Guardianship

Has a legal guardian been established? Yes No

Guardian's name _____ Telephone _____ Email _____
Address _____

Probable future costs (annual)

Anticipate annual future expenses for your loved one, which may change over time.

Care assistance \$ _____
Education \$ _____
Housing \$ _____
Lifestyle \$ _____
Medical/Dental \$ _____

Trusts

Have any trusts been established for your child's benefit? Yes No

Name of trust _____ Date created _____
Trust tax ID number _____ Trust type _____
Name of trustee _____ Date appointed _____
Name of co-trustee _____ Date appointed _____
Name of successor trustee _____ Date appointed _____
Who established the trust? _____

Assets that will fund the trust

If additional space is needed, please attach information about other assets.

	Financial institution	Amount	Owner	Beneficiary
Savings	_____	_____	_____	_____
Bonds	_____	_____	_____	_____
Mutual funds	_____	_____	_____	_____
Stocks	_____	_____	_____	_____
Annuities	_____	_____	_____	_____
Life insurance	_____	_____	_____	_____
Other	_____	_____	_____	_____

Has the trust document been reviewed to make sure it's free from wording that specifically designates funds to cover necessities already provided by SSI, Medicaid or Medicare (such as food, shelter, clothing or medical and dental care)? Yes No Date verified _____

Have ownership and/or beneficiary designations been updated to make sure the trust is named, rather than the individual? Yes No Date verified _____

Life insurance

Additional life insurance policies

Company	Policy number	Insured	Owner	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Letter of Intent

Have you created a Letter of Intent, outlining the future care and lifestyle desired for your family member with special needs?

Yes - Please attach.

Date _____ Location _____

No - Please ask me for a complimentary Letter of Intent template (F72274-28).

The information provided in this fact finder may be used by your advisor to help develop a recommendation for you, the client. The values contained in this document are provided and confirmed by you, the client. This document is not a statement or a guarantee of account values. Any inaccuracies within this document may impact the recommendation provided to you.

This information should not be considered as tax or legal advice. You should consult your tax or legal advisor regarding your own tax or legal situation.

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