

SPECIAL NEEDS TRUST QUESTIONNAIRE

Your Information:

Name: _____

Address: _____

Telephone No.: _____

Social Security No.: _____

Date of Birth: _____

Trustee Information:

Full Name: _____

Address: _____

Telephone No.: _____

Relationship to Beneficiary: _____

Social Security No.: _____

Date of Birth: _____

Alternate Trustee Information (If your Trustee dies or is unable to serve):

Full Name: _____

Address: _____

Telephone No.: _____

Relationship to Beneficiary: _____

Your Treating Physician Information:

Name: _____

Address: _____

Telephone No.: _____

Disability & Trust Information:

Disability Caseworker Name: _____

Address: _____

Telephone No.: _____

What is your Disability? (Diagnosis, difficulties, etc.): _____

What is the amount to be put into the Trust?: _____

Where was the money derived from?: _____

Income Information:

What benefits do you receive? How much? (e.g. Medicaid, OMAP, Disability, etc.):

What is your current income? What is the source of that income?: _____