DONALD D. VANARELLI ▲■◆●
WHITNEY W. BREMER
CHEN LI●◆
Of Counsel
ERIC A. STRULOWITZ

▲ *Certified Elder Law Attorney*
By The National Elder Law Foundation
Accredited by The American Bar Association
● *Also Admitted in New York*
■ *Accredited Professional Mediator*
◆ *Accredited Veterans Attorney*

LAW OFFICE of DONALD D. VANARELLI

242 ST. PAUL STREET, WESTFIELD, NJ 07090
TELEPHONE: 908-232-7400
FACSIMILE: 908-232-7214
E-MAIL: dvanarelli@dvanarelli.com
WEB SITE: www.dvanarelli.com

PROVIDING:
ELDER LAW SERVICES
ESTATE PLANNING AND TRUST ADMINISTRATION
MEDICAID AND PUBLIC BENEFITS PLANNING
SPECIAL NEEDS PLANNING
GUARDIANSHIP SERVICES
WILL CONTESTS AND PROBATE LITIGATION
NURSING HOME LAW AND LITIGATION
VA BENEFITS PLANNING
FAMILY LAW SERVICES
COLLABORATIVE LAW
MEDIATION SERVICES
SOCIAL SECURITY DISABILITY APPEALS

CONFIDENTIAL CLIENT QUESTIONNAIRE for a DISABLED PERSON with SPECIAL NEEDS

This questionnaire is intended to elicit the information we need to help you to preserve the disabled person's eligibility for needs-based government benefits when the disabled person receives money as the result of a tort recovery, equitable distribution or an inheritance. The more complete and accurate your responses, the better we will be able to help you. Please bring the completed form with you to our first meeting. **All information will be held in the strictest confidence.**

Today's Date _____

1. Name of Person Completing Questionnaire: _____

Address: _____

Tel. Home: _____ Tel. Bus: _____

Cell Phone No. _____ E-mail Address: _____

Fax: _____Your Relationship to Elder: _____

_____

Purpose of This Visit? _____

A: REFERRAL

2. By whom were you referred to this office? Name _____
Street Address _____
City _____ State_____ Zip_____

Referral is:
___ Attorney ___ Previous Client of Donald D. Vanarelli
___ Financial Planner ___ Website
___ Other _____

Have you visited our website at www.dvanarelli.com? Yes ☐ No ☐
If yes, do you have any ideas for improving our website? If so, please discuss: _____

B: DISABLED PERSON

3. Full Name: _____

Street Address _____

City_____ State_____ Zip_____

Home Phone No. _____ Fax No._____

E-mail address _____ Cell No._____

Birth Date_____ Social Security No._____

Medicaid No._____ Medicare Claim ._____

Medicaid Case Worker:_____ Phone No.:_____

4. Disabled Person is: ☐ Married ☐ Single If married, please provide the name and address of the spouse: _____
_____

5. Disabled Person: ☐ Has Capacity ☐ Is Incapacitated

6. Disabled Person is: ☐ A U.S. Citizen ☐ A Qualified Alien ☐ Don't Know

7. Has a guardian been appointed for the disabled person? ☐ Yes ☐ No If so, please list: Name of Guardian _____
Address_____
City_____ State_____ Zip_____
Telephone No. _____
(Please attach court orders, guardianship letters, and related pleadings.)

8. Disabled Person Suffers from:

☐ Anoxic Brain Injury
☐ Asperger Syndrome
☐ Attention Deficit Disorder (ADD)
☐ Attention Deficit - Hyperactivity Disorder (ADHD)
☐ Autism
☐ Bi-Polar Disorder
☐ Blindness
☐ Borderline Personality Disorder
☐ Brain Injury
☐ Cerebral Palsy
☐ Deafness
☐ Depression
☐ Developmentally Delayed
☐ Dissociative Disorder
☐ Downs Syndrome
☐ Epilepsy
☐ Fragile X Syndrome
☐ Mental Illness
☐ Mental Retardation
☐ Obsessive Compulsive Disorder
☐ Paraplegia
☐ Quadriplegia
☐ Rett Syndrome
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Spina Bifida
☐ Tourette Syndrome
☐ Traumatic Brain Injury
☐ Other: _____

9. Is the disabled person living at home or in an institution? ☐ Home ☐ Institution. If in an institution, please list:
Name of Institution_____
Address _____
City_____ State_____ Zip_____
Telephone No._____
Name of Contact Person_____

10. If the disabled person is living with either of his/her parents, what is the marital status of the disabled person's parents?
_____
_____
_____

C: PERSONAL INJURY ATTORNEY

11. Name of Attorney _____
Address _____
City_____ State_____ Zip_____
Telephone No._____ Fax No._____

D: INSURANCE COMPANIES

12. Insurance Companies:

12.1 ☐ Health ☐ Auto ☐ Other
Name of Company_____
Address _____
City_____ State_____ Zip_____
Telephone No._____Fax No._____
Name of Contact Person_____
Name of Policyowner_____

12.2 ☐ Health ☐ Auto ☐ Other
Name of Company_____
Address _____
City_____ State_____ Zip_____
Telephone No._____Fax No._____
Name of Contact Person_____
Name of Policyowner_____

E: GENERAL FINANCIAL INFORMATION

13. Your Estimated Net Worth: $_____
Your Spouse's/Partner's Estimated Net Worth: $_____

REAL ESTATE

TYPE AND LOCATION	COST	**CURRENT VALUE**	OWNERSHIP*

* H=Husband; W=Wife; P=Partner; JT=Joint Tenants; TC= Tenants-in-Common.

BANK ACCOUNTS

Bank Name and Address	Type of Acct*	Account Number	Owner	Amount on Deposit

* Checking Account (CA), Savings Account (SA), Certificates of Deposit (C), Money Market Accts (MMA)

STOCKS, BONDS, TREASURY NOTES

NAME	ESTIMATED COST	ESTATE VALUE	OWNERSHIP*

* H=Husband; W=Wife; P=Partner; JT=Joint Tenants; TC= Tenants-in-Common.

PARTNERSHIPS AND OTHER INVESTMENTS

NAME OF INVESTMENT	TYPE OF INVESTMENT	CURRENT VALUE	OWNERSHIP*

* H=Husband; W=Wife; P=Partner; JT=Joint Tenants; TC= Tenants-in-Common.

RETIREMENT ACCOUNTS: IRAs, KEOUGHS, 401(K), ETC.

TYPE OF ACCOUNT	TAX BASIS	CURRENT VALUE	OWNERSHIP*

* H=Husband; W=Wife; P=Partner; JT=Joint Tenants; TC= Tenants-in-Common.

LIFE INSURANCE and ANNUITY CONTRACTS

Company Name and Address	Owner	Cash Surrender Value / Death Benefit	Policy Number	Primary / Alternate Beneficiaries

BUSINESS INTERESTS

Company	Owner	Type*	Percentage Ownership	Value	Buy/Sell Agreement

*Corporation (C), Sole Proprietorship (SP), Partnership (P), Limited Liability Co. (LLC)

LAW OFFICE of DONALD D. VANARELLI

VALUABLE PERSONAL PROPERTY: AUTOMOBILES, JEWELRY, COLLECTIONS AND THE LIKE

ASSET	OWNER	VALUE

DEBTS

CREDITOR	AMOUNT	PROPERTY SECURED

14. Do you or your spouse own any burial plots? Yes ☐ No ☐ If yes, please provide the name and address of the cemetery, and attach copy of deed(s).

15. Have you or your spouse prepaid your funeral? Yes ☐ No ☐ If yes, provide the name and address of funeral home, and attach copy of funeral contract.

F: INHERITANCES

16. Does the disabled person or spouse expect to inherit real or personal property? Yes ☐ No ☐. If yes, please explain: _____

17. Is the disabled person or spouse the beneficiary of any trust? Yes ☐ No ☐ If yes, provide the terms and conditions of the trust, amount of principal, etc. _____

18. Is the disabled person or spouse the beneficiary of any insurance policy, annuity or the like? Yes ☐ No ☐ If yes, provide the terms and conditions of the policy, amount of death benefit, etc. _____

G: TRUSTEES

19. Name of Initial Trustee _____
Address _____
City_____ State_____ Zip_____
Telephone No._____ Fax No._____

20. Name of Alternate Trustee _____
Address _____
City_____ State_____ Zip_____
Telephone No._____ Fax No._____

21. Name of Second Alternate Trustee _____
Address _____
City_____ State_____ Zip_____
Telephone No._____ Fax No._____

H: BACKGROUND OF DISABILITY / INJURY

22. What was the date of the disability/injury and how did it occur?
_____
_____

23. Describe the nature and extent of the disabilities/injuries.
_____
_____
_____

24. Describe the disabled person's current physical, mental, and emotional condition. _____
_____
_____

25. Where does the disabled person live and with whom?
_____
_____

26. What type of medical services is the disabled person receiving?
_____
_____
_____

27. What type of social services is the disabled person receiving?
_____
_____

28. What is the disabled person's prognosis?
_____
_____

29. Where will the disabled person likely reside in the future?

_____

_____

30. Will nursing home care probably be required? ☐ Yes ☐ No

31. What is the disabled person's life expectancy? _____

32. Who are the disabled person's present caregivers? Please describe them.

_____

_____

32.1. From whom is the disabled person receiving home health care?
☐ Agency ☐ Family Members

32.2. If from an agency, please list:
Name of Agency_____
Address _____
City_____ State_____ Zip_____
Telephone No._____Fax No._____
Name of Contact Person_____

32.3. If the disabled person is receiving care from family members, please list the following:
Name of Family Member_____
Address _____
City_____ State_____ Zip_____
Telephone No._____
Is the family member a certified health-care provider?
☐ Yes ☐ No

33. Please attach any medical reports of the disabled person relating to any accidents. Be sure to include the following:
- Discharge summary from original hospital, if applicable
- Report from medical exams at time of the diagnosis or injury
- Report of the most recent medical examination by a physician, preferably within six months
- Reports of significant hospitalization, surgeries, or rehabilitation from the date of the accident

I: THE PLAINTIFFS

(In the case of a money judgment awarded in a lawsuit or a settlement)

34. Is there more than one plaintiff? ☐ Yes ☐ No If so, who are they? _____

_____

35. What is the nature of the plaintiffs' claims? _____
_____
_____
_____

36. What are the plaintiffs' damages? _____
_____
_____

37. If a plaintiff is a parent, does he or she have reimbursable costs?
☐ Yes ☐ No If so, for what? _____
_____

38. Who is the tortfeasor?_____
Is there a qualified assignment? ☐ Yes ☐ No

J: THE SETTLEMENT

(In the case of a money judgment awarded in a lawsuit or a settlement)

39. How much is the overall settlement or judgment?_____

40. What are the costs?_____

41. What is the contingency fee?_____

42. Are fees owed to more than one lawyer? ☐ Yes☐ No

43. Will there be any attorney liens filed in the case? ☐ Yes ☐ No

44. Will the amount of the settlement or judgment make the Plaintiff whole or will Plaintiff's injuries be permanent? _____
_____

45. Is the settlement: a lump sum? ☐ Yes ☐ No
a structured settlement? ☐ Yes ☐ No

46. If there is no settlement, is there an offer? ☐ Yes ☐ No If yes, how much is the offer? _____ What does plaintiff's attorney realistically think the case is worth? _____

47. How much of the settlement is allocated to medical claims of the disabled person?_____

48. What is the allocation of that portion of the settlement not allocated to medical claims of the disabled person? _____

49. Has a lifecare plan been prepared for disabled person?☐Yes ☐ No
If yes, please attach a copy of the plan.

K: MEDICAID LIENS, MEDICARE CLAIMS, AND SUBROGATION CLAIMS

50. Was plaintiff receiving Medicaid at any time since the accident? ☐ Yes ☐ No

51. Is there a Medicaid lien? ☐ Yes ☐ No If so, how much? _____

52. Has Medicaid been notified of the commencement of the action or of the proposed settlement, arbitration award, or jury verdict? ☐ Yes ☐ No If yes, please attach a copy of the notice.

53. Has the Medicaid lien already been negotiated? ☐ Yes ☐ No Have any releases been signed? ☐ Yes ☐ No

54. Was plaintiff receiving Medicare at any time since the accident? ☐ Yes ☐ No

55. Is there a Medicare claim? ☐ Yes ☐ No If yes, how much? _____

56. Has Medicare been notified of the commencement of the action or of the proposed settlement, arbitration award, or jury verdict? ☐ Yes ☐ No If yes, please attach a copy of the notice.

57. Has the Medicare claim already been negotiated? ☐ Yes ☐ No Have any releases been signed? ☐ Yes ☐ No

58. Has plaintiff received any benefits from worker's compensation? ☐ Yes ☐ No
If yes: Name of Carrier_____
Address _____
City_____ State_____ Zip_____
Telephone No._____ Fax No._____
Name of Contact Person_____

59. Are there any insurance subrogation claims in the case? ☐ Yes ☐ No If yes, please describe the nature and extent of the subrogation claim. _____
_____

60. Has the disabled person received any other government benefits? ☐ Yes ☐ No If yes, please describe the benefits _____
_____

61. Has disabled person received Medicaid in any other state? ☐Yes ☐ No If yes, please list the states in which Medicaid benefits were paid_____

L: COURT PROCEEDINGS

62. Do you believe court approval of the settlement is necessary? ☐ Yes ☐ No If not, why not? _____
_____

63. Assuming court approval is necessary, who are the interested parties? What are their names and addresses?

Name_____
Address _____
City_____ State_____Zip_____
Name_____
Address _____
City_____ State_____ Zip_____
Name_____
Address _____
City_____ State_____ Zip_____

64. Who signed the engagement agreement with the plaintiff's counsel?_____

65. In which court is the proceeding pending? _____

66. What is the docket number of the case?_____

67. Who is the presiding judge?_____

M: PUBLIC BENEFITS

68. Is anyone in the disabled person's household or immediate family receiving public benefits? ☐ Yes ☐ No Who? _____

69. What public benefits are family or household members receiving?
_____

70. What public benefits is the disabled person receiving? (Please list all public benefits: Medicaid, Special Waiver Programs, SSI, SSD, Workers' Comp, Medicare, etc.) _____
_____
_____

71. Is it likely the disabled person will require public benefits in the future? ☐ Yes ☐ No If yes, why?_____

72. Does the disabled person have any income? ☐ Yes ☐ No If yes, from what source?_____

73. Has the disabled person made an application for public benefits that is still pending? ☐ Yes ☐ No

74. Has the disabled person ever received public benefits (other than Medicaid) in any other state? ☐ Yes ☐ No If yes, list the states in which benefits were paid and the nature of the benefit. _____

N: EXPECTATIONS OF THE DISABLED PERSON

75. What does the disabled person hope to achieve or plan to do with this settlement/inheritance? _____
_____
_____

76. What kinds of services does the disabled person now need that he/she is not receiving? _____
_____
_____

77. What kinds of equipment or personal property does the disabled person hope to purchase with this settlement/inheritance? _____
_____

78. If the disabled person is living with parents or a spouse, what kinds of equipment, personal property, or renovations would the parents or spouse like to see result from this settlement? _____
_____
_____
_____

O: ESTATE PLANNING

79. Does the disabled person presently have any estate planning documents (wills, trusts, powers of attorney)? ☐ Yes ☐ No If yes, please attach copies.

80. Do the parents or spouse have any estate planning documents? ☐ Yes ☐ No If yes, please attach copies.

P: WHO IS THE CLIENT?

81. Who will be the client of the Law Offices of Donald D. Vanarelli?
Counsel? ☐Yes ☐ No
Disabled Person? ☐Yes ☐ No

82. Who is the guarantor of the fees of the Law Offices of Donald D. Vanarelli?
_____
_____

Q: ADDITIONAL INFORMATION

83. Do you believe there is any other information I should be aware of? Yes ☐ No ☐ If yes, please explain: _____
_____

CERTIFICATION

I understand that the recommendations and advice which you give, and any documents you prepare, will be based on the accuracy and completeness of the disclosures made herein. **Thus, I certify that the information provided is true and correct in all respects to the best of my knowledge and belief.**

_____ _____
Client **Client**