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 THIRD-PARTY SPECIAL NEEDS TRUST

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 an inheritance or from a third-party. 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 disabled person:_____

_____

Purpose of This Visit? _____

## A: REFERRAL

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

Referral is:
___ Attorney
___ Financial Planner
___ Previous Client of the Law Office of Donald D. Vanarelli
___ 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: _____

## PART B: PERSONAL INFORMATION

3. **Husband**

Name: _____
Address: _____
_____
Phone: _____
Email: _____
Date of birth: _____
SSN: _____
Driver's License No. and Name of Issuing State: _____
U. S. citizen?: ☐ Yes ☐ No
Veteran?: ☐ Yes ☐ No

4. **Wife**

Name: _____
Address: ☐ Same as Husband
☐ Different: _____
Phone: _____
Email: _____
Date of birth: _____
SSN: _____
Driver's License No. and Name of Issuing State: _____
U. S. citizen?: ☐ Yes ☐ No
Veteran?: ☐ Yes ☐ No

5. Will you be establishing the Special Needs Trust? ☐ Yes ☐ No If no, who will establish the Special Needs Trust? _____

6. FAMILY, FRIENDS, and OTHERS.

Date of Marriage:_____
Place of Marriage:_____
Prior Marriages:_____
Children from Prior Marriages:_____
Continuing Support Obligations:_____
_____
_____

LAW OFFICE of DONALD D. VANARELLI

## CHILDREN

| Name | Address | Age | Sex | Telephone Number | Spouse's Name |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Please explain any special medical, educational, or other extraordinary personal or financial needs of any child:_____

_____

## GRANDCHILDREN

| Name | Address/Parent Name | Age | Sex | Marital Status | Spouse's Name |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please explain any special medical, educational, or other extraordinary personal or financial needs of any grandchild: _____

_____

_____

Are all your children / grandchildren in good health? Yes ☐ No ☐
Are any of your children / grandchildren blind? Yes ☐ No ☐
Are any of your children / grandchildren disabled? Yes ☐ No ☐

Do any of your children / grandchildren receive SSI, Medicaid or other government benefits? Yes ☐ No ☐

Do you or any of your family members have any problems with:

| | | | |
|---|---|---|---|
| AIDS? | Yes ☐ No ☐ | Drug Addiction? | Yes ☐ No ☐ |
| Alcoholism? | Yes ☐ No ☐ | Spendthrift? | Yes ☐ No ☐ |
| Marital Difficulty? | Yes ☐ No ☐ | | |

LAW OFFICE of DONALD D. VANARELLI

**PARENTS (YOURS AND YOUR SPOUSE'S)**

| Name | Address | Age | Sex | Marital Status | Spouse's Name |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please explain any special medical or financial needs of any parent:

_____

_____

7. Is anyone (other than your spouse) dependent upon you for support? If so, identify the person, and provide the reason for, and extent of, support: _____

_____

## C: DISABLED PERSON

8. 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.:_____

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

_____

10. Disabled Person: ☐ Has Capacity ☐ Is Incapacitated

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

12. 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.)

13. 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: _____

14. 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_____

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

16. 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. _____
_____

17. 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. _____
_____

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

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

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

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

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

23. Do the disabled person's parents have any estate planning documents? ☐ Yes ☐ No If yes, please attach copies.

## D: GENERAL FINANCIAL INFORMATION

24. Your Estimated Net Worth: $_____
25. 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)

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

| ASSET | OWNER | VALUE |
|---|---|---|
| | | |
| | | |

## DEBTS

| CREDITOR | AMOUNT | PROPERTY SECURED |
|---|---|---|
| | | |
| | | |

26. 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).

---

27. 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.

## E: ESTATE DOCUMENTS

28. **YOUR LAST WILL AND TESTAMENT.**

## PRIMARY BENEFICIARIES

Identify those to whom you want to leave your estate, and in what amounts.

| Name | Address | Relationship | Percentage or Amount of Estate |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## ALTERNATIVE BENEFICIARIES

If the persons identified above as Primary Beneficiaries die before you, who do you want to inherit your estate instead?

| Name | Address | Relationship | Percentage of Estate or Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## SPECIFIC GIFTS

Do you or your spouse wish to make any specific gifts of tangible personal property, real estate, cash, securities, etc?

| Specific Gift | Name Of Beneficiary | Address | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## CHARITIES YOU WISH TO BENEFIT

| Name of Charity | Address | Percentage of Estate or Amount |
|---|---|---|
| | | |
| | | |

## EXECUTORS

Who do you want to be the executor of your estate? Please list alternate executors.

| Name | Address | Relationship | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## TRUSTEES

Who do you want to manage any trusts that may be established now, or under your will? Please list alternate trustees.

| Name | Address | Relationship | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## GUARDIANS

Who do you want to designate in your will as caretakers for people who may be minor children or incompetent? Please list alternatives.

| Name | Address | Relationship | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

29. **LIVING WILLS.**

A living will and health care proxy inform medical providers of your wishes concerning your care, and authorize someone, as your agent, to make health care decisions for you.

## YOUR LIVING WILL INFORMATION

Doctor: (Name and Address) _____
Priest/Rabbi/Spiritual Advisor: (Name and Address) _____
Agent: _____
Alternate Agent: _____

Medical procedures (When you have an incurable disease, are in a long-term coma or are severely demented): [ ] May be withheld [ ] May not be withheld [ ] Agent may decide [ ] Other: _____

Nutrition/Hydration: [ ] May be withheld [ ] May not be withheld [ ] Agent may decide [ ] Other: _____

Pain Medication/Treatment: [ ] Should be provided [ ] May be withheld [ ] Agent may decide [ ] Other: _____

Do you direct that all health care decisions made by your Agent on your behalf be consistent with the teachings of your religion or faith? [ ] Yes [ ] No If yes, please describe your religion:_____

Autopsy: [ ] May be performed [ ] May not be performed [ ] Other: _____

Organ Donation: [ ] Yes [ ] No [ ] Other: _____

Disposition of Remains: [ ] Cremation [ ] Burial
[ ] Agent May Decide
[ ] As described in my Will or funeral contract
[ ] Other (specify): _____

Memorial Service: [ ] Yes, in accordance with _____ religion
[ ] No [ ] Other: _____

Euthanasia: [ ] Agree [ ] Disagree

Do Not Resuscitate Orders: [ ] May be established [ ] Other: _____
[ ] May not be established

Other Personal Preferences:_____

## SPOUSE/PARTNER'S LIVING WILL INFORMATION

Doctor: (Name and Address) _____
Priest/Rabbi/Spiritual Advisor: (Name and Address) _____

Agent: _____
Alternate Agent: _____

Medical procedures (When you have an incurable disease, are in a long-term coma or are severely demented): [ ] May be withheld [ ] Agent may decide
[ ] May not be withheld [ ] Other: _____

Nutrition/Hydration: [ ] May be withheld [ ] May not be withheld
[ ] Agent may decide [ ] Other: _____

Pain Medication/Treatment: [ ] Should be provided [ ] May be withheld
[ ] Agent may decide [ ] Other: _____

Do you direct that all health care decisions made by your Agent on your behalf be consistent with the teachings of your religion or faith? [ ] Yes [ ] No If yes, please describe your religion:_____

Autopsy: [ ] May be performed [ ] May not be performed
[ ] Other: _____

Organ Donation: [ ] Yes[ ] No [ ] Other: _____

Disposition of Remains: [ ] Cremation [ ] Burial
[ ] Agent May Decide
[ ] As described in my Will or funeral contract
[ ] Other (specify): _____

Memorial Service: [ ] Yes, in accordance with _____ religion
[ ] No [ ] Other: _____

Euthanasia: [ ] Agree [ ] Disagree

Do Not Resuscitate Orders: [ ] May be established [ ] Other: _____
[ ] May not be established

Other Personal Preferences:_____

30. **POWER OF ATTORNEY.**

A durable power of attorney provides the authority to a designated person to act on your behalf in the event you are disabled, or otherwise unable to act.

**YOUR POWER OF ATTORNEY INFORMATION**

Please indicate, in order, the names, addresses and relationships of persons to serve as your agents.

| Name | Address | Relationship | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Answer the following questions as best you can. Add any additional concerns or points in the margins:**

Should agents have authority to act: [ ] Only if you are disabled (i.e., springing); or [ ] Should their authority be immediate (i.e., durable)?

Should multiple agents be required to act jointly? Yes ☐ No ☐

Should the last agent be given the authority to appoint a successor so that the power remains valid? Yes ☐ No ☐

Should agents be given compensation? Yes ☐ No ☐

Should agents have power over retirement assets? Yes ☐ No ☐

Do you want your agent(s) to be able to make gifts of your property if necessary for tax reasons or to protect your assets?: Yes ☐ No ☐

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

☐ No restrictions, I trust my agent(s) to make the right decision.

☐ My restrictions are:_____

## SPOUSE/PARTNER'S POWER OF ATTORNEY INFORMATION

Please indicate, in order, the names, addresses and relationships of persons to serve as your agents.

| Name | Address | Relationship | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Answer the following questions as best you can. Add any additional concerns or points in the margins:**

Should agents have authority to act: [ ] Only if you are disabled (i.e., springing); or [ ] Should their authority be immediate (i.e., durable)?

Should multiple agents be required to act jointly? Yes ☐ No ☐

Should the last agent be given the authority to appoint a successor so that the power remains valid? Yes ☐ No ☐

Should agents be given compensation? Yes ☐ No ☐

Should agents have power over retirement assets? Yes ☐ No ☐

Do you want your agent(s) to be able to make gifts of your property if necessary for tax reasons or to protect your assets?: Yes ☐ No ☐

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

☐ No restrictions, I trust my agent(s) to make the right decision.

☐ My restrictions are:_____

## F: ADDITIONAL INFORMATION

31. 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**