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In addition to completing this form, please complete our Lifetime Planning Intake Form available by [clicking here](#).

SPECIAL NEEDS TRUSTS INTAKE FORM

INFORMATION ABOUT INDIVIDUAL COMPLETING THIS FORM:

Name: _____ Relationship to Person with Special Needs: _____
Street Address: _____ City/State/Zip: _____
Telephone #: _____ Email: _____

INFORMATION ABOUT PERSON WITH SPECIAL NEEDS:

Full Name: _____
Street Address _____
City _____ State _____ Zip _____
Telephone #: _____ E-mail address _____
Birth Date _____ Social Security No. _____
Medicaid No. _____ Medicare Claim No. _____
Gender: ☐ Male ☐ Female ☐ Other (please specify): _____

Person with special needs suffers from (check all that apply):

- ☐ Brain injury
☐ Autism
☐ Paraplegia
☐ Quadriplegia
☐ Down Syndrome
☐ Cerebral Palsy
☐ Fragile X Syndrome
☐ Rett Syndrome
☐ Spina bifida
☐ Other _____

Date of Onset: _____
Prognosis: _____

Person with special needs receives (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> SSI | <input type="checkbox"/> Medicaid | <input type="checkbox"/> SSDI |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Medicaid Waiver | <input type="checkbox"/> Subsidized Housing |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Psychiatric Institutionalization | |
| <input type="checkbox"/> Other Public Benefits _____ | | |

If person with special needs is not receiving any of these benefits, which, if any, have been filed for?

- | | |
|--|--|
| <input type="checkbox"/> SSI | Date of Filing: _____. Has there been a determination of disability by the Social Security Administration?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> SSDI | Date of Filing: _____. Has there been a determination of disability by the Social Security Administration?
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Medicaid | Date of Filing: _____ |
| <input type="checkbox"/> Medicare | Is the disabled person likely to be eligible for Medicare within the next 30 months? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Medicaid Waiver | Date of Filing: _____ |
| <input type="checkbox"/> Subsidized Housing | Date of Filing: _____ |
| <input type="checkbox"/> Group Home | Date of Filing: _____ |
| <input type="checkbox"/> Psychiatric Institution | Date of Filing: _____ |
| <input type="checkbox"/> Other Public Benefits _____ | |

MISCELLANEOUS INFORMATION:

1. Living Arrangement

Person with special needs is living: ☐ At home ☐ In an institution or group home:

Name of institution or group home _____

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ E-mail address _____

Name & Title of Contact Person _____

2. Citizenship

Person with special needs is: ☐ A U.S. Citizen ☐ A Resident Alien ☐ Unknown

3. Competency

Person with special needs is:

☐ A competent adult ☐ An adult believed to be mentally incompetent

☐ An adult who has been adjudicated incompetent by a court of law

☐ A minor expected to be **competent** at age 18 ☐ A minor expected to be **incompetent** at age 18

4. Social Security

If applicable, please provide address of Social Security office with which the person with special needs has contact:

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ Fax No. _____

Name of Claims Representative _____

5. Parents of Young Adult with Special Needs

What is the marital status of the disabled person's parents, if the disabled person is living with either of them?

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Name of Father _____ Living? ☐ Yes ☐ No

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ E-mail Address _____

U.S. Citizen? ☐ Yes ☐ No If no, explain under what legal right the father resides in this country.

Name of Mother _____ Living? ☐ Yes ☐ No

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ E-mail Address _____

U.S. Citizen? ☐ Yes ☐ No If no, explain under what legal right the mother resides in this country.

6. Guardianship/Conservatorship

Is the person with special needs subject to a guardianship? ☐ Yes ☐ No

Subject to a conservatorship? ☐ Yes ☐ No

If yes, please provide the following:

Name of Guardian(s) _____

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ E-mail Address _____

Name of Conservator(s) _____

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ E-mail Address _____

Please attach court orders, guardianship and/or conservatorship letters and related pleadings.

7. Person with Special Needs Family

Person with Special Needs is: ☐ Married ☐ Single

If married, spouse's name _____

If person with special needs has children, please give their names and ages: _____

ESTATE PLANNING DOCUMENTS:

1. Person with Special Needs Currently Has In Place:

☐ Power of Attorney ☐ Advance Medical Directive

2. Family of Person with Special Needs:

Family members who might leave inheritance to disabled person have the following existing documents:

☐ Wills ☐ Revocable Living Trust

☐ Powers of Attorney/Advance Directives ☐ Third-party Special Needs Trust

REFERRAL INFORMATION:

How did you hear about the Farr Law Firm?
