

<p>FAIRFAX, VIRGINIA OFFICE: 10640 Main Street, Suite 200 Fairfax, Virginia 22030 Phone: 703-691-1888</p> <p>FREDERICKSBURG, VIRGINIA OFFICE: 511 Westwood Office Park Fredericksburg, Virginia 22401 Phone: 540-479-1435</p>	<p>FARR LAW FIRM</p> <p>A PROFESSIONAL CORPORATION</p> <p>WWW.FARRLAWFIRM.COM WWW.EVERYTHINGELDERLAW.COM TOLL-FREE TEL: 800-399-FARR FAX: 703-345-9999</p>	<p>DISTRICT OF COLUMBIA OFFICE: 1775 I St NW, Suite 350 Washington, DC 20006 Phone: 202-587-2797</p> <p>ROCKVILLE, MARYLAND OFFICE: 1 Research Court, Suite 450 Rockville MD 20850 Phone: 301-519-8041</p>
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In addition to completing this form, you must complete our Lifetime Planning Intake Form available by [clicking here](#).

SPECIAL NEEDS TRUSTS INTAKE FORM

INFORMATION ABOUT INDIVIDUAL COMPLETING THIS FORM:

Name: _____ Relationship to Disabled Person: _____
 Street Address: _____ City/State/Zip: _____
 Telephone #: _____ Email: _____

INFORMATION ABOUT DISABLED PERSON:

Full Name: _____
 Street Address _____
 City _____ State _____ Zip _____
 Telephone #: _____ E-mail address _____
 Birth Date _____ Social Security No. _____
 Medicaid No. _____ Medicare Claim No. _____

Gender: Male Female

Disabled Person suffers from (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Autism | <input type="checkbox"/> Paraplegia |
| <input type="checkbox"/> Quadriplegia | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Rett Syndrome | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Other _____ | | |

Date of Disability: _____

Prognosis: _____

*Evan Farr is Certified as an Elder Law Attorney by the National Elder Law Foundation. Dean Anderson and Justin Cohee are Associate Attorneys. Tim Barkley is Of Counsel to the firm.

MISCELLANEOUS INFORMATION:

1. Living Arrangement

Disabled person is living: At home In an institution or group home

If in an institution or group home, please list:

Name of Facility _____

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ E-mail address _____

Name & Title of Contact Person _____

2. Citizenship

Disabled person is: A U.S. Citizen A Resident Alien Unknown

3. Competency

Disabled Person 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 disabled person has contact:

Street Address _____

City _____ State _____ Zip _____

Telephone #: _____ Fax No. _____

Name of Claims Representative _____

5. Disabled Person's Parents

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 disabled person the subject of a guardianship? Yes No

Is the disabled person the subject of 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. Disabled Person's Family

Disabled person is: Married Single

If married, Spouse's Name _____

Name of Child #1 _____ Age _____

Is this child a stepchild? Yes No

Name of Child #2 _____ Age _____

Is this child a stepchild? Yes No

Name of Child #3 _____ Age _____

Is this child a stepchild? Yes No

Name of Child #4 _____ Age _____

Is this child a stepchild? Yes No

8. Distribution on Death of Disabled Person

After any required Medicaid payback, the remaining trust assets should be distributed to:

Spouse of Disabled Person

Children of Disabled Person: Equally

Children of Disabled Person: Unequally, as follows: _____

Other: _____

9. Age Requirements

If any contingent beneficiary of the trust is relatively young, what will the age requirement be for distribution?

Trustee Retains Distribution until age: 30 35 Other _____

Withdrawal Rights: 1/3 at Age _____

1/2 at Age _____

All at Age _____

Other _____

10. Real Estate

Will the Trust own any real estate? Yes No

If yes, provide the following:

Street Address _____

City _____ State _____ Zip _____

___ Single Family Dwelling ___ Townhouse ___ Condominium

ESTATE PLANNING DOCUMENTS:

1. Disabled Person Currently Has In Place:

Health Care POA / Living Will Power of Attorney

2. Disabled Person's Family:

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

Wills Living Trust

Powers of Attorney Third-party Special Needs Trust

REFERRAL INFORMATION:

How did you hear about the Farr Law Firm?
