

# McAndrews Law Offices, P.C.



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## SPECIAL NEEDS TRUST QUESTIONNAIRE

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

Name of Beneficiary with a disability: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth of Beneficiary: \_\_\_\_\_

Social Security Number of Beneficiary: \_\_\_\_\_

**Nature of Disability of Beneficiary** - If available, please provide a document which describes the nature and extent of the disability and state whether any guardian has ever been appointed for the disabled beneficiary.

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Name of proposed settlor (must be parent, grandparent, guardian, or via court order)

\_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

Name(s) and Address(es) of Contingent Beneficiary(s) who might receive any remaining Trust monies upon the death of the disabled beneficiary after payment of future medicaid liens accrued during operation of the Trust.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Source of monies for trust** (e.g., settlement of litigation, inheritance, Social Security back payments, gift)

Amount (including payment schedule if structured settlement is involved):

Proposed Trustee(s) (individual or corporate fiduciary - if corporate: name of contact person):

\_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

Proposed Alternate Trustee(s) (if any)

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Beneficiary with a disability: \_\_\_\_\_

**Caption of Any Underlying Litigation** (if any):

\_\_\_\_\_

**Type(s) and Amount(s) of Public Benefits** received by beneficiary

Supplemental Security Income (SSI) \_\_\_\_\_

Medical Assistance (MA) \_\_\_\_\_

Mental Health/Mental Retardation Benefits (MH/MR) \_\_\_\_\_

Social Security Disability Income (SSDI) \_\_\_\_\_

Medicare \_\_\_\_\_

Section 8 Housing \_\_\_\_\_

Other \_\_\_\_\_

**If Beneficiary is employed:**

Name of Employer: \_\_\_\_\_

Approximate Monthly Salary: \_\_\_\_\_

**Referred by:** \_\_\_\_\_