

## INTAKE FOR SPECIAL NEEDS TRUST

**This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to the appointment.**

### I. FACTUAL BACKGROUND

1. What is the claimant's:

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

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

Telephone Number: \_\_\_\_\_ Marital Status: M \_\_\_\_\_ S \_\_\_\_\_

Social security number: \_\_\_\_\_ Date of Birth \_\_\_\_\_

List Claimant's Minor Children, and date of birth: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Explain the nature of the claimant's disability. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Is the claimant mentally competent? YES \_\_\_\_\_ NO \_\_\_\_\_

4. Where does the claimant live (home, public housing, group home, skilled nursing facility)? \_\_\_\_\_

\_\_\_\_\_

5. U.S. Citizen? Yes  No

6. Veteran? Yes  No

### II. MEDICAL DATA

1. Health

Diagnosis \_\_\_\_\_

\_\_\_\_\_

Prognosis \_\_\_\_\_

\_\_\_\_\_

Course of Treatment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Physician

Full Name of Primary Physician \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

3. Health Insurance

Do you have a Medicare Supplement Health Policy?      Yes       No

If Yes, attach policy of summary of benefits

**III. THE SETTLEMENT**

1. How much is the overall settlement? \_\_\_\_\_

2. How is the settlement being paid? \_\_\_\_\_

3. What are the costs? \_\_\_\_\_

4. What is the contingency fee? \_\_\_\_\_

5. Are fees owed to more than one lawyer? YES \_\_\_\_\_ NO \_\_\_\_\_

6. Will there be any attorney liens filed in the case? YES \_\_\_\_\_ NO \_\_\_\_\_

**IV. THE INHERITANCE**

1. How much is the inheritance? \_\_\_\_\_

2. Who is the inheritance from? \_\_\_\_\_

\_\_\_\_\_

3. When will the Inheritance be paid? \_\_\_\_\_

4. Is Court approval necessary for payment of the Inheritance? \_\_\_\_\_ Yes \_\_\_\_\_ No. If Yes, provide date of anticipated Court approval. \_\_\_\_\_

5. Please provide name, address and telephone number of Trustee, Personal Representative

and attorney(s) administering the trust, will or estate. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please attach copies of applicable trust or will documents and copies of all Probate Proceedings.

**V. PROTECTIVE PROCEEDINGS**

1. Has a conservator, guardian or guardian ad litem been appointed?

YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please attach a copy.

**VI. PUBLIC BENEFITS**

1. Is the claimant or **anyone** in the claimant's household or immediate family receiving public benefits? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what public benefits? \_\_\_\_\_

2. Is the claimant eligible for Medicare? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, since when? \_\_\_\_\_

3. If Claimant is not eligible for Medicare, has the claimant filed for SSD? YES \_\_\_\_\_

NO \_\_\_\_\_. If YES, specify date claimant first received SSD. \_\_\_\_\_

4. What public benefits is the claimant receiving? (Please list all public benefits; i.e., Medicaid, special waiver programs, SSI, SSDI, Medicare, etc. and attach Medicaid Card)

\_\_\_\_\_  
\_\_\_\_\_

5. Is the Claimant currently residing in government subsidized housing? YES \_\_\_\_\_

NO \_\_\_\_\_.

6. Is it likely claimant will require public benefits assistance in the future?

YES \_\_\_\_\_ NO \_\_\_\_\_

7. Does the claimant have any income? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, from what source? \_\_\_\_\_

8. Has someone made an application for public benefits that is still pending?  
YES \_\_\_\_\_ NO \_\_\_\_\_

**VII. MISCELLANEOUS**

1. What does the claimant hope to achieve with this settlement or inheritance?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What kinds of services does the claimant now need that he or she is not receiving? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What kinds of equipment or personal property does the Claimant hope to purchase with this settlement?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Where would the Claimant like to be in two years? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. If the Claimant is living with parents or a spouse, what kinds of equipment, personal property, real property or renovations would the parents or spouse like to see come out of the settlement? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. By law a disability trust must be established for the benefit of the Claimant by the Claimant,

the Claimant's parent, grandparent, guardian, or by a court. Please indicate first choice to establish the trust and if that choice is other than Claimant or Court provide name, address and relationship. \_\_\_\_\_  
\_\_\_\_\_

7. Do you have any other legal issues which I should be aware of? Yes  No   
If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VIII. ESTATE PLANNING**

1. Does the Claimant presently have any estate planning documents (wills, trusts, powers of attorney)? If so, please attach copies of all documents.
2. Do the parents or spouse of the Claimant have any estate planning documents? Please describe fully or attach copies.
3. Does Claimant desire to have remaining assets of Trust to pass to any specified person or entity? If Yes, please provide full name, date of birth, relationship to Claimant and current address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Does Claimant have a first and second choice for Trustee of Trust? If Yes, provide name and address. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IX. ATTACHMENTS**

Please attach copies of the following documents to this form

4. Copies of Claimant's estate planning documents such as Last Will and Testament, Trust documents, Financial Durable Power of Attorney documents and Health Care Advanced Directives.
5. Attach copies of all pending applications for public benefits.
6. Attach a copy of Medicaid Card or other Public Assistance Identification Card

7. The Claimant should provide a list of all assets, liabilities and the amount and source of monthly income.

**X. REFERRAL**

By Whom Were You Referred To This Office?

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_

**XI. CERTIFICATION**

The undersigned hereby represents to the LAW OFFICES OF BRADLEY J. FRIGON, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Claimant or Claimant's Representative:

\_\_\_\_\_