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INHERITANCE INTAKE FORM (For First Party Special Needs Trust)

Name: _____

Address: _____

Mailing Address:

Home phone: _____ Work phone: _____

Cell phone: _____ Fax: _____

Email: _____

Preferred way to contact? _____

This information is extremely important. Your accuracy and completeness in completing this form will assist in our analysis of your case.

I. FACTUAL BACKGROUND

1. Client Information:

Name: _____

Address: _____

Telephone Number: _____ Marital Status: M _____ S _____

Social security number: _____ Date of Birth _____

List Client's Spouse or Partner and any Minor Children. Provide date of birth for any minor children and indicate if children are from current spouse/partner or a previous marriage or relationship:

2. Who will the client inherit money from?

3. Is the client mentally competent? YES _____ NO _____

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

5. Who is the client's primary care provider? _____

6. U.S. Citizen? Yes No

7. Veteran? Yes No

8. Is the client represented by an attorney? YES _____ NO _____. If Yes, identify counsel below:

II. MEDICAL DATA

1. Health

Diagnosis _____

Prognosis _____

2. **Health Insurance**

Is the client covered under a health insurance policy? Yes No

If Yes, attach copy of policy or summary of benefits: If a government or military health insurance coverage, just indicate type of plan:

What are the conditions for continued coverage or when is coverage expected to cease?

If the client is covered under a group health plan, is the client's continued coverage under the group plan as a result of a spouse or other family member? Yes No

If the client's coverage is the result of a spouse or other family member, indicate how long the client can maintain coverage under the group health plan.

III. THE INHERITANCE

1. How much is the estimated inheritance? _____

2. Who is the client receiving the inheritance from? _____

3. Has the client received any prior partial distributions? Yes____, No____.

If Yes, how much and when? _____

4. Date probate proceedings were opened and location of court: _____

5. Anticipated date when probate will be closed or trust administration completed: _____

IV. PROTECTIVE PROCEEDINGS

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

YES _____ NO _____

If yes, please attach a copy of Order.

V. PUBLIC BENEFITS

1. Is the client or **anyone** in the client's household or immediate family receiving public benefits? YES _____ NO _____
If yes, what public benefits? _____
2. Is the client eligible for Medicare? YES _____ NO _____
If yes, since when? _____
3. If Client is not eligible for Medicare, has the client filed for SSDI? YES _____ NO _____
If YES, specify date client first received SSDI: _____
4. What public benefits is the client receiving? (Please list all public benefits; i.e., Medicaid, special waiver programs, SSI, SSDI, Food Stamps, TANF Medicare, etc.)

5. Is the client currently residing in government subsidized housing? YES _____ NO _____
6. Is it likely client will require public benefits assistance in the future? YES _____ NO _____
7. Does the client have any other income? YES _____ NO _____
If yes, from what source? _____
8. Does the client have any other assets? YES _____ NO _____
If yes, please identify: _____
9. Has someone made an application for public benefits that is still pending?
YES _____ NO _____

VI. MISCELLANEOUS

1. What does the client hope to achieve with this inheritance?

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

3. What kinds of equipment or personal property (vehicle, specialized medical equipment, etc) does the client hope to purchase with this inheritance?

4. Does the client want to purchase a home? Yes No , If Yes, how much is the purchase price? _____

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

VII. ATTACHMENTS

If available, please attach copies of the following documents to this form:

- (a) Copies of all pending applications for public benefits.
- (b) A copy of Medicaid Card or other Public Assistance Identification Card.
- (c) Health Insurance policy or summary of benefits.
- (d) A copy of the will or trust.
- (e) A copy of the petition and order to open and close probate proceedings.

VIII. REFERRAL

By Whom Were You Referred To This Office?

Name _____
Street Address _____
City _____ State _____ Zip _____

NO ATTORNEY CLIENT RELATIONSHIP IS CREATED UNTIL A FEE AGREEMENT IS SIGNED BY THE CLIENT.

IX. 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 Client or Client's Representative:

DATE: _____