



THIRD-PARTY SPECIAL NEEDS TRUSTS INTAKE FORM

COMPASSIONATE GUIDANCE. TRUSTED PROCESS.

This form helps gather information to prepare a Third-Party Supplemental Needs Trust. Complete this form entirely and submit it **72 hours** before your scheduled appointment. Failure to do so may result in consultation cancellation. Submitting in advance allows for thorough review and productive discussion. Detailed information helps streamline planning, but providing every document or detail beforehand is unnecessary. Completing this form does not create an attorney-client relationship. All information is confidential. Provide all documentation of assets owned by the Beneficiary.

DISCLAIMER: Your privacy matters. Everything you share here is kept strictly confidential and used only to prepare for your consultation. Just a heads-up: completing this form doesn't establish an attorney-client relationship. Our initial meeting is simply a starting point for us to explore your needs—no pressure, no obligations until we both agree to move forward. **A formal agreement must be signed in order to become an OFFICIAL FOREVER LEGAL CLIENT.**

Today's Date: _____

How did you hear about FOREVER LEGAL? _____

SETTLOR INFORMATION

Settlor's Full Name *[First Name, Middle, Last Name]:* _____

Settlor's Date of Birth: _____

Settlor's Social Security Number: _____

Settlor a U.S. Citizen? ☐ Yes ☐ No

Settlor's Address *[Street Address or PO Box, City, State, Zip]:*

Settlor's County of Residence: _____

Settlor's Relationship to the Beneficiary: _____

Is there a Co-Settlor? ☐ Yes ☐ No

If yes:

Co-Settlor's Full Name *[First Name, Middle, Last Name]:* _____



Co-Settlor's Date of Birth: _____

Co-Settlor's Social Security Number: _____

Co-Settlor a U.S. Citizen? ☐ Yes ☐ No

Co-Settlor's Address *[Street Address or PO Box, City, State, Zip]*:

Co-Settlor's County of Residence: _____

Relationship to the Beneficiary: _____

BENEFICIARY INFORMATION

Beneficiary's Full Name *[First Name, Middle, Last Name]*: _____

List any other former names: _____

Beneficiary's Date of Birth: _____

Beneficiary's Driver's License Number: _____

Is the Beneficiary a U.S. Citizen? ☐ Yes ☐ No

Beneficiary's Social Security Number (Optional): _____

Beneficiary's Address *[Street Address or PO Box, City, State, Zip]*:

Beneficiary's County of Residence: _____

Beneficiary's Email Address: _____

Beneficiary's Phone Number: _____

BENEFICIARY EMPLOYMENT INFORMATION

Is the Beneficiary currently employed? ☐ Yes ☐ No

If yes:

Occupation/Position: _____

Employer Name, Address, and Contact Information: _____

Estimated Annual Income from Salary, Bonuses, etc: _____



BENEFICIARY FAMILY INFORMATION

Does the Beneficiary have a spouse? ☐ Yes ☐ No

If yes:

Name: _____

Date of Birth: _____

Social Security Number: _____

Address: _____

Phone Number: _____

Email Address: _____

BENEFICIARY DISABILITY INFORMATION

Describe the Beneficiary's underlying disabilities: _____

Was the onset of the disability prior to age 22? ☐ Yes ☐ No

Is the Beneficiary competent to handle funds? ☐ Yes ☐ No

Is the Beneficiary subject to a Guardianship? ☐ Yes ☐ No

If yes:

Describe whether Guardianship of the Person, the Estate, or both:

Provide Guardian's contact information: _____

Date of Guardianship: _____

Does the Beneficiary require supervision? ☐ Yes ☐ No

Does the Beneficiary have issues with substance abuse? ☐ Yes ☐ No

Is the Beneficiary developmentally disabled? ☐ Yes ☐ No

If yes, describe: _____

Describe Beneficiary's current therapeutic, educational, vocational, and social services:



BENEFICIARY BENEFITS

Name of representative payee for social security benefits, if applicable: _____

Does the Beneficiary receive Supplemental Security Income (SSI)? ☐ Yes ☐ No

If yes, describe: _____

Does the Beneficiary receive Temporary Aid to Needy Families (TANF)? ☐ Yes ☐ No

If yes, describe: _____

Does the Beneficiary receive Section 8 Housing (HUD)? ☐ Yes ☐ No

If yes, describe: _____

Does the Beneficiary receive Social Security Disability Insurance (SSDI)? ☐ Yes ☐ No

If yes, describe: _____

Does the Beneficiary receive Supplemental Security Income (SSI) for disability before age 22? ☐ Yes ☐ No

If yes, describe: _____

Does the Beneficiary receive Medicare? ☐ Yes ☐ No

If yes, describe: _____

Does the Beneficiary have Private Health Insurance? ☐ Yes ☐ No

If yes, describe/Insurer: _____

Describe any other benefits not mentioned: _____

BENEFICIARY ASSETS

Does the Beneficiary own any Real Property [land] or Mineral Interests? ☐ Yes ☐ No

If yes, list each residence, state, approximate value, and mortgage balance for each:

State the name(s) which appear on the title, if known, and state whether the property is co-owned: _____



Does the Beneficiary have a Savings Account? ☐ Yes ☐ No

If yes, list the account type, financial institution, any beneficiaries, and approximate value for each account: _____

Does the Beneficiary have a Checking Account? ☐ Yes ☐ No

If yes, list the account type, financial institution, any beneficiaries, and approximate value for each account: _____

Does the Beneficiary have a Brokerage Account? ☐ Yes ☐ No

If yes, list the account type, financial institution, any beneficiaries, and approximate value for each account: _____

Does the Beneficiary have an Individual Retirement Account [IRA]? ☐ Yes ☐ No

If yes, list Institution/Custodian, balance, any beneficiaries: _____

Does the Beneficiary have an Employee Benefit Plan, 401K Plan? ☐ Yes ☐ No

If yes, list Plan type, Institution/Administrator, balance, any beneficiaries for each plan: _____

For defined contribution plans, such as 401K plans, please list the current account balance:

For defined contribution plans please also list your yearly contribution:

For defined benefit plans, please indicate either your projected monthly benefit or projected lump sum payment period for stock options, please indicate current value:

Does the Beneficiary own any Life Insurance or Annuities? ☐ Yes ☐ No

If yes, list Insurance Company/Administrator, cash value, payoff amount, any beneficiaries for each: _____

Has the Beneficiary been designated as a recipient on another person's life insurance policy? ☐ Yes ☐ No

If yes, list Insurance Company/Administrator, Insured Party, Policy Owner, and cash value: _____

Does the Beneficiary have any other major assets that will be included in the Trust [fine



artwork or jewelry, pending lawsuits, etc.]? ☐ Yes ☐ No

If yes: _____

Does the Beneficiary have any anticipated inheritance? ☐ Yes ☐ No

If yes:

Name of person who may leave you something: _____

Relationship: _____

Rough estimate of amount: _____

Does the Beneficiary own a Business? ☐ Yes ☐ No

If yes:

Name of Business: _____

Business industry: _____

Is this a family-owned business? _____

Address: _____

EIN Number: _____

List the Owners/Members/Shareholders of your business and the ownership percentage for each:

Has your business been valued? _____

Approximate value: _____

Number of employees: _____

Please indicate which of the following your business already has in place, if any:

☐ Operating Agreement

☐ Corporate Minutes

☐ Bylaws

☐ Buy-Sell Agreement

Do you have whole or part ownership in another/other business? ☐ Yes ☐ No

If yes, explain: _____

Does the Beneficiary own any Automobiles (including boats and trailers)?



Make and Year, Date Acquired, Owner on Title, Issuer State, Value, Loan amounts. Include whether the automobile is co-owned.: _____

BENEFICIARY LIABILITIES

List the Beneficiary's liabilities (*excluding mortgages or car loans listed above*).

Consumer Debts (Provide description and amounts): _____

Business Debts (Provide description and amounts): _____

Guarantees (Provide description and amounts): _____

TRUSTED INDIVIDUALS

Please provide the names of trusted individuals or entities who can help manage the Beneficiary's care and financial decisions.

Provide Name, Contact Information and Relationship to the Beneficiary:

TRUST CONTINGENCY PLANNING

If a change in the law makes the Beneficiary ineligible for benefits due to the trust, what action would you prefer? *[Select One]*

☐ Continue the Trust

☐ Terminate the Trust. If so, select one or both of the following:

☐ Distribute the trust assets to a trusted person to use the proceeds for the Beneficiary's benefit.

Name and contact information of trusted person:

☐ Use the trust assets to purchase exempt assets or services for the Beneficiary.

If the Beneficiary becomes gainfully employed and no longer dependent on public benefits, what would you like to do? *[Select One]*

☐ Continue the Trust



- ☐ Terminate the Trust and distribute the trust assets to the Beneficiary.

If so, complete the following: How many consecutive months must the Beneficiary be gainfully employed?

Do you want to allow the Beneficiary to decide who will get the remainder of the trust assets when the Beneficiary dies (“Testamentary Power of Appointment”)? *[Select one or more]*

- ☐ Yes, let the Beneficiary decide who will get the remaining trust assets, with no restrictions.

- ☐ Yes, with restrictions. *[Select one or more]*

☐ Beneficiary’s descendants

☐ Beneficiary’s spouse

☐ Your descendants

☐ Charities

☐ Religious organizations

- ☐ No

How would you like the remaining trust assets to be distributed upon the Beneficiary’s death? *[Please answer even if the above option was selected, in case the Beneficiary does not decide.]*

ADDITIONAL INFORMATION

Is there additional information you would like FOREVER LEGAL to know in advance of our consultation?

Are there any specific questions you have that should be addressed in our consultation?

CERTIFICATION



I hereby affirm that the information contained in this questionnaire is complete and accurate to the best of my/our knowledge.

Signature

Date

**DO NOT EMAIL THIS INTAKE FORM. TO
ENSURE YOUR INFORMATION
REMAINS SECURE UPLOAD YOUR
FORM IN MYCASE. THANK YOU!**