

SPECIAL NEEDS TRUST BENEFICIARY PROFILE

Name: _____ DOB (mo/day/year): _____

Street Address: _____ Age _____

City/State/Zip _____ Soc. Sec. No. _____

Telephone _____

Type of Residence (home, group home, apt., other) _____

Please List Family Members or Other Persons Assisting or Supporting Individual: _____

General Nature of Disability / Brief Medical History: _____

Diagnoses: _____

Medications (Please list all prescription and over-the-counter, if known) _____

Current Health Care Providers: (Name, address, telephone, if known) _____

Does the Beneficiary Have Any of the Following: (Check existing, and list names where applicable)

Will _____

Power of Attorney _____

Living Will _____

Guardian _____

Health Care Power of Attorney _____

Benefits Currently Receiving: (List ID numbers and dollar amount if known)

SSI _____

VA Benefits _____

SSDI _____

Food Stamps _____

Medicaid _____

Subsidized Housing – Type _____

Medicare _____

Other _____

Private Insurance: (List ID numbers and amounts if known)

Medicare Supplement _____

Private Health Insurance _____

Long Term Care _____

Disability _____

Other _____

Proposed Source of Funds for Special Needs Trust: _____

Please list separately on firm legal planning form any assets or income the Beneficiary has in his/her own name, and the monetary value of those assets.