Date: _____

Rice & Quattrone, PC
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Cherry Hill, NJ 08034
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Fax: 856-673-0052

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ESTATE AND MEDICAID PLANNING QUESTIONNAIRE

PLEASE PRINT LEGIBLY

Note: **If you are completing this form for a parent, other family member, or friend, please supply information for such person in the questionnaire, not yourself, but supply your name, address and telephone number and email address in this space below:**

_____ _____
Your Name Telephone Number

_____ _____
Address Email Address (if any)

SPOUSE'S NAME (1): _____
First MI Last

_____ _____
Also Known As (if any) Date of Birth

SOCIAL SECURITY #: _____

SPOUSE'S NAME (2): _____
First MI Last

_____ _____
Also Known As (if any) Date of Birth

SOCIAL SECURITY #: _____

HOME ADDRESS: _____

_____

_____

HOME TELEPHONE: _____

SPOUSE'S (1): CELL: _____ EMAIL: _____

SPOUSE'S (2): CELL: _____ EMAIL: _____

SPOUSE'S (1) OCCUPATION: _____

EMPLOYER NAME: _____

ADDRESS: _____

WORK TELEPHONE: _____

SPOUSE'S (2) OCCUPATION: _____

EMPLOYER NAME: _____

ADDRESS: _____

WORK TELEPHONE: _____

CHILDREN (if any):

CHILD #1

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #2

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #3

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #4

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #5

_____
Name

Address

Telephone No. Email Age DOB Marital Status

Born of this Marriage or prior Marriage?

GRANDCHILDREN (if any):

GRANDCHILD #1

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #2

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #3

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #4

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #5

Name

Address

Age DOB Marital Status

Name of Parent

ARE ALL OF YOUR CHILDREN AND GRANDCHILDREN IN GOOD HEALTH? Yes ____ No ____

ARE ANY OF YOUR CHILDREN OR GRANDCHILDREN RECEIVING SSI, MEDICAID OR OTHER FORM OF GOVERNMENT ASSISTANCE? Yes ____ No ____

DATE OF MARRIAGE: _____

IS THIS SPOUSE'S (1) FIRST MARRIAGE? Yes ____ No ____

If no, please list date(s) and method of termination (death, divorce, annulment) of prior marriages including name(s) of former spouse(s): _____

_____

IF DIVORCED, indicate whether you entered any property settlement agreements with a former spouse:
Yes ____ No ____

IS THIS SPOUSE'S (2) FIRST MARRIAGE? Yes ____ No ____

If no, please list date(s) and method of termination (death, divorce, annulment) of prior marriages including name(s) of former spouse(s): _____

_____

IF DIVORCED, indicate whether you entered any property settlement agreements with a former spouse:
Yes ____ No ____

ARE YOU BOTH UNITED STATES CITIZENS? Yes ____ No ____

If no, please indicate which spouse is not a U.S. and country of citizenship:

_____

YOU BOTH IN GOOD HEALTH Yes ____ No ____

If no, please indicate the diagnosis of your ailment(s): _____

_____

PLEASE INDICATE IF EITHER OF YOU HAVE HAD RECENT HOSPITALIZATIONS: Yes ____ No ____

If yes, please indicate the reason for your hospitalizations: _____

_____

PLEASE INDICATE IF THERE IS ANY PLANNED OR CURRENT PLACEMENT IN A NURSING HOME OR ASSISTED LIVING FACILITY: Yes ____ No ____

DO EITHER OF YOU HAVE LONG TERM CARE INSURANCE? Yes ____ No ____

If yes, please indicate from which company, what the monthly or daily benefit is and the terms:_____

_____

DO EITHER OF YOU HAVE HEALTH INSURANCE THAT SUPPLEMENTS MEDICARE ("Medigap")?
Yes ____ No ____

If yes, please indicate which company:_____

Amount of premium: $_____

ARE EITHER OF YOU A VETERAN OF THE UNITED STATES ARMED FORCES? Yes ____ No ____

IF EITHER OF YOU IS A VETERAN, ARE YOU RECEIVING TRI-CARE? Yes ____ No ____

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior Gold? Yes ____ No ____

If you are a Pennsylvania resident are you currently receiving benefits under the PACE program?
Yes ____ No ____

HOW WERE YOU REFERRED TO OUR FIRM? _____

PLEASE LIST NAME, ADDRESS AND TELEPHONE NUMBER OF THE FOLLOWING:

Family/Corporate Attorney _____

Accountant _____

Financial Planner/Broker _____

Banker _____

Insurance Agents _____
Homeowners

_____
Auto

_____
Life

PLEASE INDICATE WHETHER YOU HAVE EXECUTED ANY OF THE FOLLOWING ESTATE PLANNING DOCUMENTS:

		No	Yes – Date Signed	Do you want to make changes?
Will	Spouse #1			
	Spouse #2			
Living Will (a/k/a Advance Directive or Healthcare Power of Attorney)	Spouse #1			
	Spouse #2			
Financial Power of Attorney	Spouse #1			
	Spouse #2			
Trust	Spouse #1			
	Spouse #2			

Assets: Name: _____

Date: _____

NON-RETIREMENT ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	✓ if None	SPOUSE'S (1)	SPOUSE'S (2)	JOINT	LIABILITIES
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD(s)					
Residence					
Other Real Estate					
(State: _____)					
Time Shares					
Businesses					
(Name: _____)					
Mutual Funds (non-retirement)					
Stocks					
Bonds					
Automobiles (make/model/year)					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS					

Assets: Name: _____

Date: _____

RETIREMENT (TAX-QUALIFIED) ASSETS (Fill in Amounts/Values)					
	✓ if None	OWNER	INSURED / ANNUITANT	BENEFICIARY	VALUE/DEATH BENEFIT
IRA'S (including rollovers)					
401(K)					
403(b)					
TIAA/CREF					
Savings Plans					
Qualified Annuities					
NON-QUALIFIED ANNUITIES					
TOTALS					

HAVE YOU BEEN GIVEN A POWER OF APPOINTMENT IN A TRUST CREATED BY ANOTHER PERSON OR IN ANOTHER PERSON'S ESTATE? Yes ____ No ____

Name: _____

Date: _____

MONTHLY INCOME

	SPOUSE (1)	SPOUSE (2)
Net Salary or Wages	$	$
Social Security	$	$
Pension	$	$
Annuity Income	$	$
Other Income	$	$
TOTAL INCOME	$	$

GIFTS

Gifts and transfers of property made to someone other than your spouse within the past 60 months (including transfers of real estate, e.g. adding a child's name to a deed)

RECIPIENT	DATE	AMOUNT
		$
		$
		$
		$
		$
		$
		$

ANTICIPATED MONTHLY ASSISTED LIVING / NURSING HOME EXPENSES (if applicable)

Name of Nursing Home/Assisted Living Facility	
Date of Admission	
Average Monthly Bill	$