

The Law Offices of Nancy M. Rice
49 Grove Street
Haddonfield, NJ 08033
618 West Ave., Ocean City, NJ 08226
Phone: 856-673-0048
Fax: 856-673-0052

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, not yourself, but supply your name, address, telephone number and email address in the space below:

Check here if you wish all correspondence/billing to this contact/address. (Note: If you do not check this box, all correspondence and/or billing will be directed to the client at the address below.)

Your Name

Telephone Number

Address

Email Address (if any)

HUSBAND'S NAME:

First MI Last

Also Known As (if any) Date of Birth

SOCIAL SECURITY #

WIFE'S NAME:

First MI Last

Also Known As (if any) Date of Birth

SOCIAL SECURITY #

HOME ADDRESS:

HOME TELEPHONE:

ARE ALL YOUR CHILDREN AND GRANDCHILDREN IN GOOD HEALTH? Yes___ No___

ARE ANY OF YOUR CHILDREN OR GRANDCHILDREN RECEIVING SSI OR OTHER FORM OF GOVERNMENT ASSISTANCE? Yes___ No___

DATE OF MARRIAGE: _____

HAVE YOU ENTERED ANY PRENUPTIAL, POSTNUPTIAL OR PROPERTY SETTLEMENT AGREEMENT WITH YOUR SPOUSE REGARDING DIVISION OF PROPERTY UPON DIVORCE OR DEATH? Yes___ No___

IS THIS HUSBAND'S 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): _____

IS THIS WIFE'S 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: _____

ARE YOU BOTH UNITED STATES CITIZENS? Yes___ No___

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

ARE 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___

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___

Yes___ No___

If yes, please indicate which company: _____

ARE EITHER OF YOU A VETERAN OF THE UNITED STATES ARMED FORCES? Yes_____ No_____

HOW WERE YOU REFERRED TO OUR FIRM? _____

WHAT TYPE OF SERVICE ARE YOU INTERESTED IN US PROVIDING FOR YOU?

- Estate Planning: Will, Trust, Power of Attorney, Living Will
- Estate or Trust Administration
- Medicaid Planning
- Estate Litigation: Will Contests, etc.
- Guardianship

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

Family/Corporate Attorney _____

Accountant _____

Financial Planner/Broker _____

Banker _____

Insurance Agent _____

Homeowners _____

Auto _____

Life _____

Name: _____

Date: _____

Assets:

ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)

	√ if None	HUSBAND	WIFE	JOINT	LIABILITIES
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD's					
Residence					
Other Real Estate					
(State: _____)					
(State: _____)					
Time Share Interests					
Business Interests					
(Name: _____)					
(Name: _____)					
Mutual Funds					
Stocks					
Bonds					
Automobiles					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS					

Name: _____

Date: _____

Assets:

ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	√ if None	OWNER	INSURED/ ANNUITANT	BENEFICIARY	VALUE/ DEATH BENEFIT
QUALIFIED FUNDS					
IRA's (including rollovers)					
401(K's)					
401(B's)					
TIAA/CREF					
Savings Plans					
Qualified Annuities					
NON-QUALIFIED ANNUITIES OR IRA's					
LIFE INSURANCE					
TOTALS					

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

Name: _____

Date: _____

Assets:

MONTHLY INCOME		
	HUSBAND	WIFE
Net Salary or Wages	\$	\$
Social Security	\$	\$
Pension	\$	\$
Other Income	\$	\$
TOTAL INCOME	\$	\$

GIFTS		
<p>Gifts made in excess of \$7,282.00 per month to someone other than your spouse within the past 36 month (including transfers of real estate (e.g., adding a child's name to a Deed):</p>		
RECIPIENT	DATE	AMOUNT
		\$
		\$
		\$
		\$
		\$
		\$

ANTICIPATED MONTHLY NURSING HOME EXPENSE (if applicable)	
Name of Nursing Home/Assisted Living Facility	
Date of Admission	
Average Monthly Bill	\$