

Date: _____

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ESTATE AND MEDICAID PLANNING QUESTIONNAIRE - SINGLE

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 and 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)

CLIENT NAME:

First MI Last

Also Known As (if any) Date of Birth

SOCIAL SECURITY # :

HOME ADDRESS:

HOME TELEPHONE:

_____ CELL: _____

EMAIL: _____

OCCUPATION:

EMPLOYER NAME:

ADDRESS:

WORK 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 ___

ARE YOU A UNITED STATES CITIZEN? Yes ___ No ___

If no, please indicate country of citizenship: _____

ARE YOU IN GOOD HEALTH? Yes ___ No ___

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

PLEASE INDICATE IF YOU HAVE HAD ANY 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 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 YOU HAVE HEALTH INSURANCE THAT SUPPLEMENTS MEDICARE ("Medigap")?

Yes ___ No ___

If yes, please indicate which company: _____

ARE YOU A VETERAN OF THE UNITED STATES ARMED FORCES? 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 Agent

Homeowners

Auto

Life

Assets:

Name: _____

Date: _____

ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	✓ if None	In Your Name Only	In Your Name - With Beneficiary listed or (POD) or ITF (In Trust For)	Joint with Someone Else	Loans/Mortgages against - liabilities
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD					
CD					
CD					
Residence					
Other Real Estate					
(State: _____)					
(State: _____)					
Time Shares					
Businesses					
(Name: _____)					
Mutual Funds					
Stocks					
Bonds					
Automobiles					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS					

Assets:

Name: _____

Date: _____

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

Assets

MONTHLY INCOME

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

GIFTS

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

Recipient	Date	Amount

ANTICIPATED MONTHLY NURSING HOME EXPENSES (if applicable)

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