

Date: _____

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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, 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:

OCCUPATION:

EMPLOYER NAME:

ADDRESS:

WORK TELEPHONE:

YOUR SIBLINGS (if applicable):

Sibling #1

Name		
Address		
Age	DOB	Marital Status

Sibling #2

Name		
Address		
Age	DOB	Marital Status

Sibling #3

Name		
Address		
Age	DOB	Marital Status

Sibling #4

Name		
Address		
Age	DOB	Marital Status

Sibling #5

Name		
Address		
Age	DOB	Marital Status

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? _____

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 _____

Assets

Name: _____

Date: _____

ASSETS (fill in Amount/Value in boxes, check left column if no such asset)

	✓ if None	In Your Name Only	In Your Name - With beneficiary listed or Payable on Death (POD) or ITF	Joint with Someone Else	Loans/Mortgages against - 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: _____)					
Mutual Funds					
Stocks					
Bonds					
Automobiles					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS					

Name: _____

Assets:

Date: _____

ASSETS (Fill in Amounts/Values)					
	✓ if None	OWNER	INSURED/ ANNUITANT	BENEFICIARY	VALUE/ DEATH BENEFIT
QUALIFIED FUNDS					
IRA's (including rollovers)					
401(K's)					
401(B's)					
TIAACREF					
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

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

GIFTS

Gifts made in excess of \$5,000 per month to someone other than your spouse within the past 36 months (including transfers of real estate(eg.adding a child's name to a Deed):

RECIPIENT	DATE	AMOUNT

ANTICIPATED MONTHLY NURSING HOME EXPENSE (if applicable)

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