Revised 05/17
EP/MP - Single

Date:______________

The Law Offices of Nancy M. Rice
1236 Brace Road, Suite F
Cherry Hill, NJ 08034
Phone: 856-673-0048
Fax: 856-673-0052

2021 New Road, Suite 9, Linwood, NJ 08221
Phone: 609-398-3447
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 and telephone number and email address in this 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 their 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'S NAME: ____

ADDRESS: ____

WORK TELEPHONE: ____

HAVE YOU EVER BEEN MARRIED? Yes____ No____
If yes, please list any applicable date(s) and method of termination (death, divorce, annulment) of prior marriages, including names of former spouse(s): ______________________________
____

CHILDREN (if applicable):

CHILD #1

____
Name

____
Address

____
Age DOB Marital Status

____
Born of this Marriage or prior Marriage?

CHILD #2

____
Name

____
Address

____
Age DOB Marital Status

____
Born of this Marriage or prior Marriage?

CHILD #3

____
Name

____
Address

____
Age DOB Marital Status

____
Born of this Marriage or prior Marriage?

CHILD #4

____
Name

____
Address

____
Age DOB Marital Status

____
Born of this Marriage or prior Marriage?

CHILD #5

Name

Address

Age DOB Marital Status

Born of this Marriage or prior Marriage?

GRANDCHILDREN (if applicable):

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 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___

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

YOUR NIECES AND NEPHEWS (if applicable):

Niece #1

Name

Address

Age DOB Marital Status

Niece #2

Name

Address

Age DOB Marital Status

Niece #3

Name

Address

Age DOB Marital Status

Nephew #1

Name

Address

Age DOB Marital Status

Nephew #2

Name

Address

Age DOB Marital Status

Nephew #3

____
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____

IF YOU ARE 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? ____

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: _______________________________

NON-RETIREMENT ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	✓ if None	In Your Name Only	In Your Name w/ Beneficiary listed of (POD) or ITF (In Trust For)	Joint w/ Someone Else	LIABILITIES
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD					
CD					
CD					
Residence					
Other Real Estate					
(State: _____________)					
Time Shares					
Businesses					
(Name: ____________)					
(Name: ____________)					
Mutual Funds					
Stocks					
Bonds					
Automobiles					
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					

DO YOU HAVE A POWER OF APPOINTMENT IN A TRUST CREATED BY ANOTHER PERSON OR IN ANOTHER PERSON'S ESTATE? ____________Yes _____________No

Assets:

Name:_____________________________

Date: ______________________________

LIFE INSURANCE

INSURED	COMPANY	POLICY #	WHOLE LIFE OR TERM?	FACE VALUE	CASH SURRENDE R VALUE	DEATH BENEFIT

MONTHLY INCOME

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 OR NURSING HOME EXPENSES (if applicable)

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