Revised 5/17
EP/MP - Married

Date:_____

The Law Offices of Nancy M. Rice

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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 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)

_____

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: _____

HUSBAND'S EMAIL: _____ CELL: _____

WIFE'S EMAIL: _____ CELL: _____

HUSBAND'S OCCUPATION: _____

EMPLOYER NAME: _____

ADDRESS: _____

WORK TELEPHONE: _____

WIFE'S OCCUPATION: _____

EMPLOYER NAME: _____

ADDRESS: _____

WORK TELEPHONE: _____

CHILDREN (if any):

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 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 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): _____
_____

IF DIVORCED, indicate whether you entered any property settlement agreements with a former spouse:

_____

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. 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 ____

If yes, please indicate which company: _____

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 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	HUSBAND	WIFE	JOINT	LIABILITIES
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD					
CD					
CD					
Residence					
Other Real Estate					
(State: _____)					
(State: _____)					
Time Shares					
Businesses					
(Name: _____)					
(Name: _____)					
Mutual Funds					
Stocks					
Bonds					
Automobiles					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS		$0	$0	$0	$0

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					$0

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 SURRENDER VALUE	DEATH BENEFIT

MONTHLY INCOME

	HUSBAND	WIFE
Net Salary or Wages	$	$
Social Security	$	$
Pension	$	$
Annuity Income	$	$
Other Income	$	$
TOTAL INCOME	$ 0	$ 0

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	$