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Special Needs Trusts | Elder Law | Long Term Care Planning | Medicaid | Probate | Wills & Trusts
Incapacity Planning | Guardianship | Developmental Disabilities | Veteran's Benefits

CONFIDENTIAL QUESTIONNAIRE

This information is extremely important. Please complete as much as possible.
Please use the back of each page to write additional information.

Date _____

Personal data of Client #1: (If Client #1 is deceased, please provide name, Social Security #, date of birth, date of death, and place of death.)

Client #1 name _____

Home address _____

City _____ State _____ Zip _____

Telephone number _____

Fax number _____

E-mail address _____

Social Security # _____

Date of birth _____

Place of birth _____

U.S. citizen: Yes _____ No _____

Resided in Florida since _____

If deceased, date of death _____

If deceased, place of death _____

Date of marriage _____

Place of marriage _____

Personal data of the Client #2: (If Client #2 is deceased, please provide name, Social Security #, date of birth, date of death, and place of death.)

Client #2 name _____

Home address _____

City _____ State _____ Zip _____

Telephone number _____

Fax number _____

E-mail address _____

Social Security # _____

Date of birth _____

Place of birth _____

U.S. citizen: Yes _____ No _____

Resided in Florida since _____

If deceased, date of death _____

If deceased, place of death _____

FAMILY MEMBERS AND OTHERS INTERESTED IN YOUR WELFARE
Please print all names as they would appear on legal documents.

Name ____ Social Security # ________________
Address _______________________________ City _____________________ State _______ Zip___
Relationship ___________________________ Telephone number ___________________________
Spouse's name________________________________ Email:_________________________________

Name ____ Social Security # ________________
Address _______________________________ City _____________________ State _______ Zip___
Relationship ___________________________ Telephone number ___________________________
Spouse's name________________________________ Email:_________________________________

Name ____ Social Security # ________________
Address _______________________________ City _____________________ State _______ Zip___
Relationship ___________________________ Telephone number ___________________________
Spouse's name________________________________ Email:_________________________________

Name ____ Social Security # ________________
Address _______________________________ City _____________________ State _______ Zip___
Relationship ___________________________ Telephone number ___________________________
Spouse's name________________________________ Email:_________________________________

Name ____ Social Security # ________________
Address _______________________________ City _____________________ State _______ Zip___
Relationship ___________________________ Telephone number ___________________________
Spouse's name________________________________ Email:_________________________________

Name ____ Social Security # ________________
Address _______________________________ City _____________________ State _______ Zip___
Relationship ___________________________ Telephone number ___________________________
Spouse's name________________________________ Email:_________________________________

PERSONAL DATA

Please list any **Health Problems** for:

Client #1: _____

Client #2: _____

Client #1's Personal physician name _____

Address _____ City _____ State _____ Zip ___

Telephone number _____

Client #2's Personal physician name _____

Address _____ City _____ State _____ Zip ___

Telephone number _____

If Client #1 and/or Client #2 were in the hospital and unable to make decisions, with whom should the doctor consult regarding **health care and living arrangements**? (List in order of priority)

_____

_____

If Client #1 and/or Client #2 were unable to carry out **financial and business decisions**, who would pay the bills and make investment decisions

_____

_____

Names of those who **would inherit the estate** of Client #1 and/or Client #2 **Share** of Estate

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Who Would Be the **Client #1's Personal Representative** (Executor)? _____

If the person selected above to be the Personal Representative is unavailable who would be the Alternate? _____

Who Would Be the **Client #2's Personal Representative** (Executor)? _____

If the person selected above to be the Personal Representative is unavailable who would be the Alternate? _____

Trustee of Revocable Living Trust _____

Are there any **disabled extended family members (children, grandchildren etc)**?

Yes_____ No ____

If yes, please complete the Disabled Individual information; if no, go to page 6.

Disabled Individual information

If the Disabled Individual has a legal representative (such as a legal guardian, conservator, representative payee, power of attorney or other agent) please provide the following information and a copy of the corresponding documentation:

Name: _____ Relationship: _____

Date of Birth _____

Address: _____

_____

Telephone: (day)_____(evening)_____

Email Address: _____

What is the Individual's disability? Also, if the Individual's condition has been medically diagnosed, what is the diagnosis?

_____

_____

_____

What is the Individual's current Prognosis?

_____

_____

_____

Insurance Information

If the Individual is covered under any policy of health care insurance, please provide the following:

Insuring Company: _____

Policy Number: _____

If the Individual is covered under any prepaid funeral or burial insurance, please provide the following:

Company: _____

Address: _____

Policy Number: _____

Government Assistance

Please indicate all forms of government assistance that the Disabled Individual **receives or is applying for** and the amounts received per month.

Social Security Retirement…….	Yes_____	No_____	Amount $_____
Supplemental Security Income (SSI)…….	Yes_____	No_____	Amount $_____
Social Security Disability Insurance (SSDI)…….	Yes_____	No_____	Amount $_____
Medicaid Institutional Care Program (Nursing Home Care)	Yes_____	No_____	Applied for ____
Medically Needy Program	Yes_____	No_____	Applied for ____
MEDS-AD……..	Yes_____	No_____	Applied for ____
PACE……..	Yes_____	No_____	Applied for ____
Home or Community Based Medicaid Waiver Programs…	Yes_____	No_____	Applied for ____
Optional State Supplementation (OSS)…….	Yes_____	No_____	Applied for ____
Home Care for the Elderly and Disabled (HCE/DA)…	Yes_____	No_____	Applied for ____
Food Stamps……..	Yes_____	No_____	Applied for ____
Veteran's Benefits (Aid and Attendance)	Yes_____	No_____	Applied for ____
Other: _____			Applied for ____

List any other government assistance that the Beneficiary receives or has applied for:

_____

_____

_____

_____

List all forms of government assistance which have been denied or discontinued to the Beneficiary, including the approximate dates:

_____

_____

_____

PERSONAL DATA (Continued)

Has Client #1 or Client #2 ever been in or worked for the following? **(Complete even if spouse is deceased.)**

*Military Service	Yes ____ No ___	Private Employer Pension Plan	Yes ___ No ____
Federal Government	Yes ____ No ____	Trade Union with Pension Plan	Yes ____ No ____
State Government	Yes ____ No ____	Railroad Retirement	Yes ____ No ____

CAREGIVER OR FRIEND

If this Questionnaire is prepared by someone other than Client #1 or Client #2, please complete the following:

Name _____

Address _____

Relationship _____ Telephone number: _____

WHO REFERRED YOU TO OUR OFFICE?

Name _____

Address _____

Telephone number _____

Did either Client serve in the military? If yes, please complete the Veteran information. If no, go to page 8.

VETERAN INFORMATION

Please indicate which individual served in the military: Client #1 ____ **Client #2** ____

What branch? _____ Active service in which war? _____

Dates of service? from_____ to _____

Does veteran have military discharge papers, i.e., DD214 or separation papers? Yes ____ No ____

Are they originals? Yes ____ No ____ What was discharge status? _____

Have **VA benefits** (Aid and Attendance) for been applied for? Yes _____ No _____

If yes, for veteran_____ or surviving spouse _____?

If yes, on what date benefits applied for? _____On what date did benefits begin? _____

If yes, what type of claim was filed? _____ Claim # _____

Is Veteran currently receiving any of the following:

Social Security ____	Medicare Part A ____	VA Pension ____
SSDI ____	Medicare Part B ____	Aid and Attendance ____
SSI ____	Medicare Part D ____	

Is spouse receiving any of the above, and if so, what?

Social Security ____	Medicare Part A ____	VA Pension ____
SSDI ____	Medicare Part B ____	Aid and Attendance ____
SSI ____	Medicare Part D ____	

VETERAN MEDICAL INFORMATION

Is veteran or his/her spouse

Living in assisted living ____ Receiving home care ____ Living in a nursing home ____

Designate who: Veteran ____ Spouse ____ Both ____

Give name, address, and phone number of facility (if applicable):

_____

_____

Monthly cost of care in facility: $_____

Has veteran or spouse filed for Medicaid for nursing home? Yes ____ No ____

Does veteran or spouse intend to file for Medicaid for nursing home in the near future? Yes ____ No ____

Who intends to file? _____

Has veteran or spouse filed for home based or other Medicaid? Yes ____ No ____

Whom: Veteran ____ Spouse ____ Both ____

Does veteran or spouse intend to file for home based or other Medicaid? Yes ____ No ____

Has veteran filed for health benefits through the VHA? Yes ____ No ____

Is the veteran receiving Tricare for Life? Yes ____ No ____

If a retired military veteran, is he/she receiving Service Connected Compensation that is combat related and has he/she filed for Combat Related Special Compensation through the DOD? Yes ____ No ____

If a retired veteran with a service connected condition, what is the current rating? _____

Did the veteran serve in Vietnam? Yes ____ No ____

Does the veteran have:

Diabetes type II _____ Parkinson's disease ____ Amyotropiclateral sclerosis (ALS) ____

Heart condition _____ Cancer ____

VETERAN FAMILY INFORMATION

If married veteran, has veteran or his/her spouse had previous marriages? Yes ____ No ____

Does veteran have proof of dissolution of all previous marriages, i.e., divorce papers and/or death certificates of prior spouses ? Yes ____ No ____

Are there dependent child(ren)? Yes ____ No ____ How many? ____

What are the age(s)? _____Does the veteran have a copy of birth certificate(s)? Yes ____ No ____

Are there dependent parent(s)? Yes ____ No ____Telephone number _____

FINANCIAL ADVISORS

Stockbroker name _____

Address _____

Telephone number _____

Accountant or CPA name _____

Address _____

Telephone number _____

HEALTH/MEDICAL INSURANCE

Does Client #1 and/or Client #2 have health or medical insurance? Yes _____ No _____

Insured	**Company name and address**	**Policy #**	**Premium amount**

LONG TERM CARE POLICIES

Does Client #1 and/ or Client #2 have any long term care policies? Yes _____ No _____

If yes, name of insured, name of company, description of coverage _____

_____

_____

MONTHLY MEDICAL EXPENSES

Expense	**Client #1**	**Client #2**
Medicare Part B		
Medicare Part C and/or D		
Private Medical Insurance		
Prescriptions		
Sitter, Assisted Living, Nursing Home		
Incontinence Supplies		
Other		
Other		
Other		
Other		
Total Medical Expenses		

MONTHLY HOUSEHOLD EXPENSES

Expense	Due Date	Present Amount	Projected Future Amount
Rent/Mortgage			
Gas/Oil			
Electric			
Water/Sewage			
Phone			
Life Insurance			
Car Insurance			
Taxes (if not included in Mortgage)			
Installment loan with _____			
Installment loan with _____			

ASSETS

MOTOR VEHICLES

Does Client #1 or Client #2 own vehicle? Yes _____ No _____

If yes, automobile _____ van _____ recreational vehicle _____ trailer _____

truck _____ boat _____ other (if other, describe) _____

Make/Model/Year	**Value**	**Owner 's name(s)**
_____	_____	_____
_____	_____	_____

Does Client #1 have current driver's license? Yes _____ No _____

Does Client #2 have current driver's license? Yes _____ No _____

BANK or BROKERAGE ACCOUNTS

(Use the back of this page for additional bank accounts.)

Checking #1 Name of bank or firm _____

Branch/Address _____

Names on account _____

Account number _____

Direct deposits to this account _____

Current balance as of (date) _____ $ _____

Interest bearing? Yes _____ No _____ Interest rate _____

Checking #2 Name of bank or firm _____

Branch/Address _____

Names on account _____

Account number _____

Direct deposits to this account _____

Current balance as of (date) _____ $ _____

Interest bearing? Yes _____ No _____ Interest rate _____

Money Market Name of bank or firm _____

Branch/Address _____

Names on account _____

Account number _____

Direct deposits to this account _____

Current balance as of (date) _____ $ _____

Interest bearing? Yes _____ No _____ Interest rate _____

Savings Name of bank or firm _____

Branch/Address _____

Names on account _____

Account number _____

Direct deposits to this account _____

Current balance as of (date) _____ $ _____

Interest bearing? Yes _____ No _____ Interest rate _____

CERTIFICATES OF DEPOSIT

CD #1 Name of bank or firm _____

Branch/Address _____

Names on account _____

Account number _____

Face amount $ _____

Current balance as of (date) _____ $ _____

Maturity date _____ Interest rate _____

Interest paid by: Monthly check mailed to owner _____ Quarterly check mailed to owner _____

Reinvested in the CD _____ Credited to checking or savings account # _____

CD #2 Name of bank or firm _____

Branch/Address _____

Names on account _____

Account number _____

Face amount $ _____

Current balance as of (date) _____ $ _____

Maturity date _____ Interest rate _____

Interest paid by: Monthly check mailed to owner _____ Quarterly check mailed to owner _____

Reinvested in the CD _____ Credited to checking or savings account # _____

CD #3 Name of bank or firm _____

Branch/Address _____

Names on account _____

Account number _____

Face amount $ _____

Current balance as of (date) _____ $ _____

Maturity date _____ Interest rate _____

Interest paid by: Monthly check mailed to owner _____ Quarterly check mailed to owner _____

Reinvested in the CD _____ Credited to checking or savings account # _____

COMMON OR PREFERRED STOCKS AND MUTUAL FUNDS

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

CORPORATE BONDS

Name(s) of owner	Company	# of bonds	Current price per bond	Total value on / /	Date purchased	Purchase price

U. S. SAVINGS BONDS

Number of U.S. Savings Bonds: Series E _____ Series EE _____ Series H_____

Total face value of all U. S. Savings bonds: $ _____ Total estimated current cash value of bonds: $_____

TAX-FREE MUNICIPALS

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

LIMITED PARTNERSHIPS, ETC.

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

G N M A 's

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

ANNUITIES

Client #1:

Company and Address	Salesman	Policy #	Owner	Beneficiary	Cash Value	Payments

Client #2:

Company and Address	Salesman	Policy #	Owner	Beneficiary	Cash Value	Payments

DEFERRED COMPENSATION /RETIREMENT ACCOUNTS

(IRA/SEP/401k/Profit sharing/Keogh)

Client #1:

Financial institution	Type (CD, stock, bonds etc.)	Value as of / /	Beneficiary	Date purchased	Purchase price	Payments

Client #2:

Financial institution	Type (CD, stock, bonds etc.)	Value as of / /	Beneficiary	Date purchased	Purchase price	Payments

BURIAL ASSETS

Location, description, and address of any **cemetery plots** Client #1 and/or Client #2 owns.

_____

_____

_____

_____

_____

Burial contracts or pre-paid funeral agreements Client #1 and/or Client #2 has purchased.

Client #1's Contract Name of purchaser_____Date of purchase _____

Name and address of funeral _____

Address_____ City _____ State _____Zip _____

Name of insurance company _____

Contract is: revocable _____ irrevocable _____Contract amount $ _____

Client #2's Contract Name of purchaser_____Date of purchase _____

Name and address of funeral _____

Address_____ City _____ State _____Zip _____

Name of insurance company _____

Contract is: revocable _____ irrevocable _____Contract amount $ _____

Does Client #1/Client #2 have a **special bank account** set aside for burial funds? Yes _____ No _____

If yes, please provide name and location of bank, account number and current balance _____

_____

REAL PROPERTY

Homestead (your residence) address _____

This residence is: a house _____ a mobile home _____ a condominium _____

other (describe, if other) _____

Names exactly as they appear on the deed _____

Is there a mortgage? Yes ___ No ___ If yes, what is the mortgage balance? $ _____

What is the tax assessor's value for this home? $ _____

If you were going to sell your home, what price would you expect to receive for it? $ _____

Date of purchase _____

Purchase price $ _____

All other real property:

Property #1 address _____

This property is: a house _____ a mobile home _____ a condominium _____

other (describe, if other) _____

Names exactly as they appear on the deed _____

Is there a mortgage? Yes ___ No ___ If yes, what is the mortgage balance? $ _____

What is the tax assessor's value for this property? $ _____

If you were going to sell this property, what price would you expect to receive for it? $ _____

Date of purchase _____

Purchase price $ _____

Do you receive rental income? Yes ____ No_____ If yes, monthly rental amount $ _____

If other real property is owned, please provide the information for the additional property on the back of this page.

LIFE INSURANCE

Client #1:

Company/ Policy #	Insured/Owner- if different, list both	Beneficiary	Date Issued	Face Value	Cash Value	Policy Loan Amount

Client #2:

Company/ Policy #	Insured/Owner if different, list both	Beneficiary	Date Issued	Face Value	Cash Value	Policy Loan Amount

LOANS (Mortgages and notes, money owed to you)

Does Client #1 or Client #2 **own a mortgage** and / or a promissory note? Yes _____ No _____

Names on the note or mortgage _____

Principal balance remaining due $ _____

Is the mortgage marketable (can it be sold?) Yes _____ No _____

If marketable, what could you sell it for? $ _____

MONTHLY INCOME SUMMARY

List all income amounts - gross and net where applicable - that Client #1 or Client #2 receives per month:

Source	**Client #1 Gross**	**Client #1 Net**	**Client #2 Gross**	**Client #2 Net**	**Name & Address of Company**
Social Security					
Private Pension					
Railroad Retire.					
Veteran's Benefits					
Civil Service					
Interest Income					
Dividend Income					
Alimony					
Rental Income					
Distributions from IRA/retirement					
Wage from Job					
Self-Employment Income					
Total Income					

Address of Record with Social Security Administration for Client #1 and/or Client #2:

☐Home address or ☐ other address (please provide) _____

_____

_____

Safety deposit box - Name of bank, name and address of branch, & box # _____

_____

Who is authorized to enter box? _____

DOCUMENTS TO PROVIDE WITH QUESTIONNAIRE

Copy of current Will, Trust, Durable Power of Attorney, Health Care Surrogate, Living Will, or other estate planning documents for Client #1 and/or Client #2, and copies of driver's licenses for Client #1 and/or Client #2.

DOCUMENTS YOU MAY NEED TO PROVIDE LATER
It is a good idea to keep these documents handy.

1. Copy of long term care policy for Client #1 and/or Client #2. Please include benefit page.

2. Copies of most current statements from financial institutions:
   For all **open** accounts: checking, savings, Certificate of Deposits, brokerage, etc.

3. Copies of stock certificates, bonds, CDs, U.S. government bonds, municipals, annuities, Individual Retirement Accounts (IRAs), or any other deferred compensation plans for Client #1 and/or Client #2.

4. Copy of any prepaid burial or cremation contract for Client #1 and/or Client #2 and copy of deed to cemetery plot owned by Client #1 and/or Client #2. Copy of any special burial bank account for Client #1 and/or Client #2.

5. Copy of deed to residence, current real estate tax bill, homeowners insurance policy and premium statement. Copy of deed(s), tax bill, and proof of insurance for any other real property owned by Client #1 and/or Client #2.

6. Copy of life insurance policies for Client #1 and/or Client #2. Pages needed are the cover page, Declarations page which lists the information about the policy and the beneficiary information.

7. Copy of any mortgage and/or promissory note **owing to** Client #1 and/or Client #2.

After you have completed the Questionnaire, please sign the following statement:

I understand that it is my responsibility to disclose correct and complete information. I hereby attest that the information I have supplied is complete and accurate to the best of my knowledge. I realize that any changes must be reported as soon as possible.

Sign: _____ Date _____

ADDITIONAL INFORMATION PAGE