Special Needs Lawyers, PA

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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

Planning questionnaire

Please print names as they would appear on legal documents.

Date ________________

Client name ________________________________

Home address ________________________________

City ________________ State ______ Zip ________

County ______________ E-mail ________________

Phone #s ________________________________

Social Security # ________________________________

Date of birth __________________ Age ____________

US citizen: Yes ___ No ___ If no, born in __________

Naturalized citizen born in ____________________

Florida resident since ________________________

Contact person if other than Client or Spouse:
Full name ________________________________
Address ________________________________
____
Phone #s ________________________________
Email ________________________________

Spouse Name ________________________________

Home address ________________________________

City ________________ State ____ Zip ___________

County ______________ E-mail ________________

Phone #s ________________________________

Social Security # ________________________________

Date of birth __________________ Age ____________

US citizen: Yes __ No __ If no, born in ____________

Naturalized citizen born in ____________________

Florida resident since ________________________

Date of marriage ________________________________

If **deceased**, full name ________________________
Date of death ________________________________

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Health of <u>Client</u>
Current and past medical or health problems____

____

⇨ Problems with memory or understanding: Yes __No___Explain________________________________

____

<u>Client</u> is currently living:
Home _______Nursing home______ALF_______Hospital____________
If in nursing home, ALF, or hospital:
Facility name ____Date of admission____________

Address __________________________City_________________ State _____Zip____________

County __________________Phone______________________Covered by **Hospice?** Yes___ No____

Expected to return home?____

<u>Client</u> physician

Name ____

Address ____

Phone #s____E-mail ______________________________

Health of <u>Spouse</u>
Current and past medical or health problems____

____

⇨ Problems with memory or understanding: Yes ___No___Explain________________________________

____

<u>Spouse</u> is currently living:
Home _______Nursing home______ALF_______Hospital____________
If in nursing home, ALF, or hospital:
Facility name ____Date of admission____________

Address __________________________City_________________ State _____Zip____________

County __________________Phone_______________________Covered by **Hospice?** Yes__ No____

Expected to return home?____

<u>Spouse</u> physician

Name ____

Address ____

Phone #s____E-mail ______________________________

Children

Please print names as they would appear on legal documents. Copy and attach additional pages, if necessary.

Name ________________________________Relation to **Client** ____________Relation to **Spouse** ___________

Address _______________________________City ______________________State ______ Zip______________

Phone #s__________________________E-mail____________________Spouse name ______________________

Date of birth_______________________Disabled: Yes___No____Special Needs __________________________

Receiving public benefits: Yes___No___Declared disabled by Social Security Administration: Yes_____No___

Deceased: Yes___No____Date of death___________Surviving children________________________________

Name ________________________________Relation to **Client** ____________Relation to **Spouse** ___________

Address _______________________________City ______________________State ______ Zip______________

Phone #s__________________________E-mail____________________Spouse name ______________________

Date of birth_______________________Disabled: Yes___No____Receiving public benefits: Yes_____No_____

Receiving public benefits: Yes___No___Declared disabled by Social Security Administration: Yes_____No___

Deceased: Yes___No____Date of death___________Surviving children________________________________

Name ________________________________Relation to **Client** ____________Relation to **Spouse** ___________

Address _______________________________City ______________________State ______ Zip______________

Phone #s__________________________E-mail____________________Spouse name ______________________

Date of birth_______________________Disabled: Yes___No____Receiving public benefits: Yes_____No_____

Receiving public benefits: Yes___No___Declared disabled by Social Security Administration: Yes_____No___

Deceased: Yes___No____Date of death___________Surviving children________________________________

Other family members and friends

Please print names as they would appear on legal documents. Copy and attach additional pages, if necessary.

Name ______________________________ Relation to **Client** _____________Relation to **Spouse** ____________

Address _______________________________City ______________________State ______ Zip______________

Phone #s____E-mail_______________________________

Name ______________________________ Relation to **Client** _____________Relation to **Spouse** ____________

Address _______________________________City ______________________State ______ Zip______________

Phone #s____E-mail_______________________________

Family issues

Describe any family issues ____

____

____

Safe deposit box

Name of bank, bank branch, box # ______________________________________

Who is authorized to enter the box? ____________________________________

Investment advisor name ____

Company name ____

Address ____

Phone #s______________________________E-mail ____________________

Accountant or CPA name ____

Company name ____

Address ____

Phone #s______________________________E-mail ____________________

Attorney name ____

Address ____

Phone #s______________________________E-mail ____________________

Who referred you to our office?

Name ______________________________Relationship __________________

Address ____

Phone #s__________________________E-mail _________________________

Estate planning

Please provide copies of all estate planning documents and photo identification with the questionnaire.

Client

Current documents

Will: Yes_______No_______

Revocable Living Trust: Yes _______No________

Amendments to Revocable Living Trust: Yes _____No ______How many?_____________

Durable Power of Attorney: Yes______No_______

Health Care Surrogate: Yes _____No_______

Living Will: Yes_______No________

Prenuptial Agreement: Yes________No_________

Beneficiary of trust of another person: Yes ______No______

Photo Identification

Driver's license: Yes____No___

Other: Yes___No_____What?___________________________

Client is

- Blind: Yes ____No____
- Has macular degeneration or cannot read documents: Yes _____No___
- Declared incompetent or cannot understand documents: Yes______No ___
- Physically unable to write name. Would sign with an X. Yes _____No_____

Spouse

Current documents

Will: Yes_______No_______

Revocable Living Trust: Yes _______No________

Amendments to Revocable Living Trust: Yes _____No ______How many?_____________

Durable Power of Attorney: Yes______No_______

Health Care Surrogate: Yes _____No_______

Living Will: Yes_______No________

Prenuptial Agreement: Yes________No_________

Beneficiary of trust of another person: Yes ______No______

Photo Identification

Driver's license: Yes____No___

Other: Yes___No_____What?___________________________

Spouse is

- Blind: Yes ____No____
- Has macular degeneration or cannot read documents: Yes _____No___
- Declared incompetent or cannot understand documents: Yes______No ___
- Physically unable to write name. Would sign with an X. Yes ___No_____

VA Benefits

Client

Military service: ⇨ **Yes __No___Unsure____**If yes, Branch of service____________________

Active duty dates: from__________________to_________________Honorable discharge: Yes ___ No____

Retired from military: Yes___No___Currently receiving benefits: Yes__No___Claim pending: Yes___No____

VA file#_____________________Monthly benefit___________Date benefits began___________________

Type of benefit

Service connected disability compensation: Yes______No_____Percentage______________

Non-service connected disability pension: Yes________No______

Special monthly pension based on Aid and Attendance or Housebound status: Yes____No_____

Enrolled in VA healthcare system: Yes_____No______

Marriages

How many times married? ___Married to____________________Date_________Place___________________

Marriage terminated by: Death ___Divorce____ Year terminated_______ Place _______________________

Copy and attach this page for additional marriages, if necessary.

Spouse

Military service: ⇨ **Yes __No___Unsure____**If yes, Branch of service____________________

Active duty dates: from__________________to_________________Honorable discharge: Yes ___ No____

Retired from military: Yes___No___Currently receiving benefits: Yes__No___Claim pending: Yes___No____

VA file#_____________________Monthly benefit___________Date benefits began___________________

Type of benefit

Service connected disability compensation: Yes______No_____Percentage__________

Non-service connected disability pension: Yes________No______

Special monthly pension based on Aid and Attendance or Housebound status: Yes____No_____

Enrolled in VA healthcare system: Yes_____No______

Marriages

How many times married? ___Married to____________________Date_________Place___________________

Marriage terminated by: Death ___Divorce____ Year terminated_______ Place _______________________

Copy and attach this page for additional marriages, if necessary.

Monthly income summary

Gross income equals what is actually received plus any deductions. Social Security deductions may include Medicare Part B and Medicare Part D premiums. Pension deductions may include taxes, health insurance, life insurance premiums, etc. Pro-rate any quarterly or yearly payments to a **monthly** amount.

Source	**Client** Gross income	**Client** Net income	**Spouse** Gross income	**Spouse** Net income
Social Security	$	$	$	$
Civil Service	$	$	$	$
Retirement pensions	$	$	$	$
Military pension (DFAS)	$	$	$	$
Annuity	$	$	$	$
IRA distributions	$	$	$	$
VA benefits	$	$	$	$
Other retirement income Source	$	$	$	$
Total Retirement Income ⇨ **Estimate and enter gross retirement income amount**	$	$	$	$
Interest and dividends	$	$	$	$
Rental income	$	$	$	$
Other income Source:	$	$	$	$
Total income ⇨	**$**	**$**	**$**	**$**

Checking, savings, money market, CDs   DO NOT LIST IRAs HERE.

Copy and attach additional pages, if necessary.

Owner(s)	Type of account	Bank name	Balance
Client, spouse, joint, joint/child, POD child, trust	Checking, savings, money market, CD	Bank of America, Wells Fargo, Fifth Third	$Current balance
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
Total **Checking, savings, money market, CDs**		DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Brokerage accounts   DO NOT LIST IRAs OR ANNUITIES HERE

Copy and attach additional pages, if necessary.

Owner(s)	Type of Security	Company	Value
Client, spouse, joint, joint/child, TOD child, trust	Brokerage account	Wachovia Securities, Smith Barney	$Current balance
			$
			$
			$
Total **Brokerage accounts**		DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Stocks, bonds, mutual funds, or other marketable securities

DO NOT LIST SECURITIES HELD IN THE BROKERAGE ACCOUNT HERE.

Copy and attach additional pages, if necessary.

Owner(s)	Type of Security	Number and Company	Value
Client, spouse, joint, joint/child, POD child, trust	Common stock, mutual fund, bonds	100 shares CocaCola, Evergreen Fund	$Current balance
			$
			$
			$
Total Stocks, bonds, mutual funds		DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Annuities

Copy and attach additional pages, if necessary.

Owner	Company	Beneficiary(s)	Value	Pay outs or Premiums
Client, spouse, joint, joint/child, POD child, trust	AIG, Aviva	Spouse, children	$100,000	Paying $400 annually Premium $200 monthly
			$	$
			$	$
Total Annuities			DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

US savings bonds

Copy and attach additional pages, if necessary.

Owner(s)	Type	Number and Face	Value
Client, spouse, joint, joint/child, POD child, trust	E, EE, H	15 EE	$Current balance
			$
Total US savings bonds		DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Loans, mortgages, promissory notes: money due to you

Copy and attach additional pages, if necessary.

Name(s) on the note or mortgage ____

Balance due: $____________________________________

Can the mortgage be sold? Yes ______________ No ______________

Amount you could sell it for? $__________________________

Total **Loans, mortgages, promissory notes**			DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Life insurance

Copy and attach additional pages, if necessary.

Company	Insured/Owner if different, list both	Beneficiary(s)	Face value	Loan amount	Cash value
Prudential	Bob Smith, owner Kay Smith, insured	Children-Rob and Kate	$	$	$
			$	$	$
			$	$	$
			$	$	$

Total **Life insurance cash value**			DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Other assets such as REITs, Oil and Gas, Limited partnership, Time shares

Copy and attach additional pages, if necessary.

Owner(s)	Type of Asset	Number and Company	Value
Client, spouse, joint, joint/child, POD child, trust			$
			$
			$
			$
			$
Total **Other assets**		DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Cash

Owner(s)	Forms of currency	Number and Company	Value
Total **Cash, gold coins**		DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Total **Available assets** **Add total boxes from pages 9, 10, 11, 12.**			DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

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Retirement accounts - IRA, SEP, 401(k), profit sharing, Keogh, etc.

Copy and attach additional pages, if needed.

Owner	Company	Beneficiary(s)	Value	Distributions
			$	$
			$	$
Total IRAs and other retirement accounts			DO NOT LEAVE BOX BLANK ⇨ Enter dollar amount, or ? if unsure, or no for none	$

Real property other than home DO NOT LIST HOME HERE.

Copy and attached additional pages, if necessary.

Property #1 Address ____

House ____Mobile home _____Condominium ______Other, describe ____________________

If mobile home: Own the lot __________ Rent the lot ________Stock ownership________________

Names on the deed ____

Is there a mortgage? Yes _____ No______ Mortgage balance? $ ____________________

Most recent county property appraiser's value $ ____________________________

What price would you expect to receive if you sold the property? $ ____________________

Date of purchase ____________________________ Purchase price $ ____________________

Is property used for business purposes?

Do you receive rental income? Yes ____________No ________ Monthly rental amount $ ______________

Property #2 Address ____

House ____Mobile home _____Condominium ______Other, describe ____________________

If mobile home: Own the lot __________ Rent the lot ________Stock ownership________________

Names on the deed ____

Is there a mortgage? Yes _____ No______ Mortgage balance? $ ____________________

Most recent county property appraiser's value $ ____________________________

What price would you expect to receive if you sold the property? $ ____________________

Date of purchase ____________________________ Purchase price $ ____________________

Is property used for business purposes?_______Explain______________________________

Do you receive rental income? Yes ____________No ________ Monthly rental amount $ ______________

Home

Address ____
House ____Mobile home _____Condominium ______Other, describe ______________________________
If mobile home: Own the lot _________Rent the lot _________Stock ownership______________________
Names on the deed ____
Is there a mortgage? Yes ______ No_____ Mortgage balance? $ ________________________________
Most recent county property appraiser's value $ ____
What price would you expect to receive if you sold the home? $ _____________________________
Date of purchase ______________________________ Purchase price $ ___________________________
Homestead exemption on property ____

Anticipated major repairs to home

Type of repair _______________________________________ Estimated cost_____________________________

Type of repair _______________________________________ Estimated cost_____________________________

Monthly shelter expenses

Mortgage/Rent (Please circle which)	**$**
Real estate taxes	**$**
Homeowners/Renters insurance (Please circle which)	**$**
Home maintenance and upkeep	**$**
Utilities	**$**
Condominium fees	**$**
Total monthly shelter expenses	**$**

Amount owed to creditors

Credit cards	**$**
Mortgage	**$**
Automobile loans	**$**
Other – what?	**$**

Client - Nursing home/assisted living facility expenses

Monthly facility charges	**$**
Monthly drug expenses	**$**
Facility paid through what date?	

If spouse is in facility, copy page and attach.

Vehicles including cars, boats, RVs, etc.

Type	Year	Make/model	Owner(s)	Value
				$
				$
				$
				$

Burial assets

⇨ **Yes__________No________Unsure_____**

If yes, complete all that apply.

Name and address of cemetery and number of cemetery plots ___________________________
____
____

Burial contracts or pre-paid funeral agreements

Contract #1 Name of owner____
Name, city, state of funeral home ____
____
Contract is: revocable _____________ irrevocable ______Contract amount $ _______________

Contract #2 Name of owner____
Name, city, state of funeral home ____
____
Contract is: revocable _____________ irrevocable ______Contract amount $ _______________

Special burial bank account

Name of bank __________Names on account _______________________Balance $ __________

Gifts of $1,000 or more to someone other than spouse within past 60 months

Transfers have been made: ⇨ **Yes ________ No ________ Unsure ________**

If yes, list below. Copy and attach additional pages, if needed.

Date	Recipient	Amount
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
Total Gifts	⇨	$

Health insurance

Client. Please complete all that apply.

Medicare

(From Medicare card) Medicare number ___________________________ Effective date ___________________

_____Medicare traditional fee for service: Part A ____ Part B ___ Part B premium$ ______________________

_____Medicare HMO: Company name ___________________ Premium$ _______Start date ______________

_____Medicare Plus: Company __________________________Premium$ _______Start date______________

_____Medicare supplement: Company ____________________ Premium$ _______Start date______________

Supplement paid for by: Individual _______ Pension deduction ______________ Other ______________

_____Medicare Part D drug benefit: Company _____________________ Premium amount$ _______________

Part D paid for by: Individual ________ Social Security deduction _________ Other ________________

Long term care insurance Company __________________Premium$ _____Benefit $ per day _____________

Maximum benefit_________Elimination period_______________If receiving, start date_____________

Other health insurance Type ____

Company__________________________________Premium$___________Start date_____________________

Spouse. Please complete all that apply.

Medicare

(From Medicare card) Medicare number ___________________________ Effective date ___________________

_____Medicare traditional fee for service: Part A ____ Part B ___ Part B premium$ ______________________

_____Medicare HMO: Company name ___________________ Premium$ _______Start date ______________

_____Medicare Plus: Company __________________________Premium$ _______Start date______________

_____Medicare supplement: Company ____________________ Premium$ _______Start date______________

Supplement paid for by: Individual _______ Pension deduction ______________ Other ______________

_____Medicare Part D drug benefit: Company _____________________ Premium amount$ _______________

Part D paid for by: Individual ________ Social Security deduction _________ Other ________________

Long term care insurance Company __________________Premium$ _____Benefit $ per day _____________

Maximum benefit________Elimination period________________If receiving, start date_____________

Other health insurance Type ____

Company__________________________________Premium$___________Start date_____________________

Client – Activities of daily living (ADLs)

Activity	Needs no help	Needs some help	Unable to do at all
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using toilet			
Grooming			
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

Spouse – Activities of daily living (ADLs)

Activity	Needs no help	Needs some help	Unable to do at all
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using toilet			
Grooming			
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			