Special Needs Lawyers, PA

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Special Needs Trusts | Elder Law | Long Term Care Planning | Medicaid | Probate | Wills & Trusts
Incapacity Planning | Guardian Advocacy | Developmental Disabilities

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.

<u>Client</u>
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?___________________________

<u>Client</u> 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_____

<u>Spouse</u>
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?___________________________

<u>Spouse</u> 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	$

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 <u>other than spouse</u> 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			