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Client Questionnaire

Our office encourages and utilizes a whole-person approach to estate planning and eldercare. This Questionnaire is designed to help us gather the information necessary to properly help you plan your estate and/or prepare for eldercare.

This Questionnaire is divided into four sections: Personal, Financial, Legal and Health. Only complete the questions that you can; we will work on any missing information together.

***PLEASE RETURN THIS QUESTIONNAIRE
TO THE OFFICE PRIOR TO THE
MEETING OR BRING IT WITH YOU.***

WE USE IT DURING THE MEETING.

Name of Person Completing this Questionnaire:

Date

I am completing this Questionnaire for: myself parent(s) spouse

Personal Information

**Name of Husband/
Father/Single Male:** _____

Date of Birth: _____

Age: _____

US Citizen: Yes No

US Veteran Yes No Dates of Service: _____

Social Security No. : _____

Address: _____

Phone: _____

Cell/Work Phone: _____

Email: _____

**Name of Wife/
Mother/Single Female:** _____

Date of Birth: _____

Age: _____

US Citizen: Yes No

US Veteran Yes No Dates of Service: _____

Social Security No. : _____

Address: _____

Phone: _____

Cell/Work Phone: _____

Email: _____

Is there any reason for haste in preparing your estate plan? Yes No

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Marriage Information

Are you married? Yes No

Is this a second marriage? Yes No

Is there a pre-nuptial or post-nuptial agreement? Yes No

Are you widowed? Yes No

Date of Death: _____

County and State: _____

Are you currently divorced and single? Yes No

Year of Final Divorce: _____

Children

Do you have Children? Yes No

How Many? _____

Are any children from a previous marriage? Yes No

Are any children formally adopted? Yes No

Are any step-children (not adopted)? Yes No

Has any child predeceased you? Yes No

Name: _____

Date: _____

Was he/she married? Yes No Children: Yes No

Child # 1

Name: _____
Birth Date: _____
Age: _____
Address: _____
Phone: _____
Married? Yes No Divorced? Yes No Children? Yes No

Child # 2

Name: _____
Birth Date: _____
Age: _____
Address: _____
Phone: _____
Married? Yes No Divorced? Yes No Children? Yes No

Child # 3

Name: _____
Birth Date: _____
Age: _____
Address: _____
Phone: _____
Married? Yes No Divorced? Yes No Children? Yes No

Child # 4

Name: _____

Birth Date: _____

Age: _____

Address: _____

Phone: _____

Married? Yes No Divorced? Yes No Children? Yes No

Child # 5

Name: _____

Birth Date: _____

Age: _____

Address: _____

Phone: _____

Married? Yes No Divorced? Yes No Children? Yes No

Grandchildren

Do you have Grandchildren? Yes No How Many? _____

Grandchild # 1

Name: _____ Age: _____

Child of: _____

Grandchild # 2

Name: _____ Age: _____

Child of: _____

Grandchild # 3

Name: _____ Age: _____

Child of: _____

Grandchild # 4

Name: _____ Age: _____

Child of: _____

Grandchild # 5

Name: _____ Age: _____

Child of: _____

Do any of your children or grandchildren have any special needs or disabilities?

Yes No

Specifics:

Are any of your children or grandchildren receiving government benefits (Medicaid, Medicare, Social Security Disability, SSI, etc)?

Yes No

Specifics:

Do any of your children or grandchildren have any financial or personal issues (poor marriage, creditors, addictions, gambling, etc.)?

Yes No

Health

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Do you have any health related issues? If yes, please list the issues/diagnoses:

Husband/Father/Single Male:

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Wife/Mother/Single Female:

Primary Physician Name and address and Hospital affiliated with:

Do you see any specialists?

Specifics:

If you are a Veteran, do you have any documented disability resulting from service?

Specifics:

Disability Rating?

Which VA facility registered with?

Are there any problems with memory or understanding, overall capacity?

Husband/Father/Individual Male: Yes No

Wife/Mother/Individual Female: Yes No

If Yes, any diagnoses of dementia or Alzheimer's disease?

Prescriptions:

Do you require assistance with the **Activities of Daily Living** (bathing, dressing, getting out of bed or up from a chair, walking, eating, toilet use, grooming, taking medication)?

Husband/Father/Individual Male: Yes No

If Yes, which ADL's is assistance needed with?

Bathing	Yes	No
Dressing	Yes	No
Transferring (out of bed or up from a chair)	Yes	No
Walking	Yes	No
Eating	Yes	No
Toileting	Yes	No
Grooming	Yes	No
Taking medication	Yes	No

Wife/Mother/Individual Female: Yes No

Which ADL's is assistance needed with?

Bathing	Yes	No
Dressing	Yes	No
Transferring (out of bed or up from a chair)	Yes	No
Walking	Yes	No
Eating	Yes	No
Toileting	Yes	No
Grooming	Yes	No
Taking medication	Yes	No

Is one spouse (or parent) in a hospital now or in the recent past? Yes No
Dates of admission, length of stay, date of transfer and discharge.

Was the hospital stay at least 3 days? Yes No

Is one spouse (or parent) in a nursing facility now or in the recent past? Yes No
Dates of admission, length of stay, date of transfer and discharge.

Is Medicare paying?

If Yes, which "day"? _____ when is 100 days?

How many Medicare days used within last 60 days? _____

Financial

Real Estate

Primary Residence - If Owned

Do you own the Residence listed as your address in Section 1: Yes No

Owner(s) on Deed: _____

Joint? Yes No

If so, is it with a "Right of Survivorship"? Yes No

Fair Market Value (FMV):\$ _____ Mortgage Amount: \$ _____

Did you purchase this home? Yes No

Purchase Price: _____ Year Purchased: _____

Have you made capital improvements to this home? Yes No

Approximate value of capital improvements: \$ _____

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Do you own other Real Estate in New York?

Yes

No

Address:

How titled:

Purchase Price: _____

Year Purchased: _____

Do you own other Real Estate outside of New York?

Yes

No

Address:

How titled:

Purchase Price: _____

Year Purchased: _____

Primary Residence – If Rented

Monthly Rent \$ _____

Inclusive of Utilities?

Yes

No

Investments
(stocks, bonds, mutual funds)

INSTITUTION	TYPE OF ACCT	OWNER	HOW TITLED	BENEFICIARY	BALANCE
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Retirement Accounts
(IRA's, 401k's, 403b's, TSA's)

INSTITUTION	TYPE OF ACCOUNT	ACCOUNT OWNER	PRIMARY & CONTIN. BENEFICIARY	BALANCE
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Education / Minor's Accounts
 (529's, UGMA/UTMA, Coverdale)

INSTITUTION	TYPE OF ACCOUNT	ACCOUNT OWNER	BENEFICIARY	BALANCE
1.				
2.				
3.				
4.				
5.				

Life Insurance

COMPANY	OWNER B	WHOLE/TERM (YRS?)	PRIMARY & CONTIN. BENEFICIARY	C V	D
1.					
2.					
3.					
4.					

Non-Qualified Annuities

COMPANY	OWNER	DEFERRED OR IMMEDIATE	PRIMARY & CONTIN. BENEFICIARY	BALANCE
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Do you have Pre-Paid funeral arrangements? Yes No Which funeral home: _____

Is it Irrevocable for Revocable? Irrevocable Revocable

Do you have burial plots? Yes No

Business Assets

Do you own an interest in a business? Yes No

Is it a family business? Yes No

Are there any Partners?

If Yes, who?

What type of entity is it?

Sole Proprietorship C Corp. S Corp. LLP/LLC

Does the business entity own assets:

If Yes, what:

Land? Inventory? Contracts?

Are there any business agreements?

Estimated Gross Sales?

Estimate Net Annual Sales?

Is there a CPA for this business, if so, who?

Miscellaneous Property

Do you have items of special value? jewelry, antiques, art, collections: Yes No

Debts

Is any money owed to you? Yes No

Do you have debt besides the mortgage(s) on your home? Yes No

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Income

WHO (Husband/Self or Wife)	TYPE (Soc. Sec., Pension, RMD's etc.)	MONTHLY AMOUNT
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1. _____
2. _____
3. _____
4. _____
5. _____

If you receive a Pension and are married,
are there any survivor benefits for your spouse? Yes No

Do you receive any payments from the Government? VA? SSI? SSD?

Long Term Care Insurance

Do you have Long Term Care Insurance? <i>Please provide copy of policy for review.</i>	Yes	No
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Health Insurance

Do you have private “employer” health insurance?	Yes	No
--	-----	----

Do you have health benefits through your former employer?	Yes	No
---	-----	----

Do you have Medicare A?	Yes	No
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Do you have Medicare B?	Yes	No
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Do you have Medicare C? Which Company? Premium?	Yes	No
---	-----	----

Do you have Medicare D? Which Company? Premium?	Yes	No
---	-----	----

Do you have New York EPIC?	Yes	No
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Do you have Medicaid?	Yes	No
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Do you have a Medicare Supplemental Policy? If yes, which Plan (A – L)? _____	Yes	No
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Legal

Inheritances

Are you currently the beneficiary of a Trust? Yes No

If Yes: Beneficiary of Principal or Income or both?
Specifics:

Do you expect to inherit assets? Yes No

From whom?

Approximately how much?

Do they have an "estate plan" in place? (especially if disabled child/grandchild exists)

Approximate time frame?

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Prior Gifts

Have you and/or your spouse ever made gift(s) in excess of \$10,000? Yes No

How much was the gift?

When made?

Was a gift tax return filed? Yes No

What year?

Who prepared and filed it the return?

Legal Documents

Do you have existing Estate Planning documents?

Will	Yes	No
Trust	Yes	No
Power of Attorney	Yes	No
Health Care Proxy	Yes	No
HIPAA Privacy Authorization	Yes	No
Living Will	Yes	No
Pre or Post Nuptial Agreement	Yes	No
Business Agreement	Yes	No

Please bring the original documents if possible.

Food for Thought

Please write the name, address and phone number on the following page all adults that may be nominated for the following roles:

1. Please think about who you would like to name as Executor and Alternate Executor of your Will. You can name more than one.
2. Please think about who you would like to name as a Trustee and Alternate Trustee if you require a Trust. You can name more than one.
3. Please think about who you would like to name as Attorney-in-Fact and Alternate Attorney-in-Fact of your Durable Power of Attorney. You can name more than one. However, if more than one person is selected, must they act together or can they act separately?
4. Please think about who you would like to name as your Health Care Agent and Alternate Health Care Agent in case you cannot make healthcare decisions yourself. You can only name one individual at a time.
5. If you have minor children, please think about who you would like to name as Guardian and Alternate Guardian if both parents are deceased. If a married couple is listed, what happens if they divorce before they are appointed and what if one passes away before appointment? Please also consider if you wish to add any directions and/or value statements for your child's potential Guardian. If you would like examples, please contact the office.
6. If you have minor children or grandchildren, please think about which age or ages you would like them to receive their entire or partial inheritance?
7. Please think about whether or not you wish to be cremated or if you wish to have any of your organs donated.
8. Please consider whether you would like to add a personal Testimony to your Last Will and Testament. While a personal Testimony is often of a spiritual nature, a paragraph or two of encouraging and supporting sentiments is often appreciated by those who will read your Last Will and Testament. For examples of Christian Testimonies, please contact the office.
9. Please think about end-of-life health care. For instance, do you want artificial hydration and nutrition through a feeding tube? Does the future 'quality' of your life have an impact on your decisions? Do you have any spiritual beliefs that should be incorporated into a Living Will so that your Health Care Agent will know your wishes?
10. If you travel, would you like to have digital copies of your health care advance directives available to a treating physician in case of an emergency?

Name: _____ Relation: _____

Address:

Phone:

Name: _____ Relation: _____

Address:

Phone:

Name: _____ Relation: _____

Address:

Phone:

Name: _____ Relation: _____

Address:

Phone:

Name: _____ Relation: _____

Address:

Phone:

Name: _____ Relation: _____

Address:

Phone:

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