PLANNING QUESTIONNAIRE
(Single)

Please complete the following questionnaire to the best of your ability. This information is most helpful to me so that I may properly plan for you and it will be held in the strictest confidence. We will review this information at our meeting. The client is the person for whom planning is being implemented

Home Telephone:______________________ Business/Cell Telephone:___________________

E-Mail Address:_______________________ Fax Number:_________________________

Your preferred method of communication: ______E-mail _____Telephone (Choose one.)

CONTACT PERSON: (person who will accompany client to meeting, if any.)

Name: ____

Address: ____

Relationship to Client: ___________________________

Telephone Number: ____________________________________

Email Address: _______________________________________

PART A: PERSONAL INFORMATION

CLIENT:

Full Name: (to be used on any legal documents prepared by our office) _______________

____

Address: ____

Social Security No.:______________________ U.S. Citizen? yes_____ no______

Birth Date: ___________________ Age:_______ Are you a veteran or the widow(er) of a veteran? yes_____ no______

What do you want to accomplish through planning? _______________________________

____

____

Occupation (past or present) ____

Currently Living: _____ at home _____ assisted living facility ____ nursing home ___ hospital

If currently living at home, who, if anyone, lives with you? ______________________
____

Nursing Home/Assisted Living Facility or Hospital: _______________________________

Date of admission: ________________________ Monthly cost: _________________________

Monthly prescription cost: _________________ Nursing home paid through: _________
Health Issues:

Physical health: ____

____

Mental health: ____

____

Any problems: __ walking ___ dressing ____ eating ____ bathing ___ continence?
___ memory ___ aggression

____

____

Do you expect to receive an inheritance? ____ If yes, please explain.___________-
____

Have you ever filed a Federal Gift Tax Return? yes_____ no____

Have you made any gifts of over $5,000 in the last five years? yes ___ no ____

If widowed, please enter name of spouse and date of death, ___________________
____

If divorced, please enter name of spouse and date of divorce. _________________
____

If divorced, was there a written property settlement agreement? yes____ no____

PART B: CHILDREN

CHILDREN'S NAMES	ADDRESS & TELEPHONE #	DATE OF BIRTH	# OF CHILDREN	# OF CHILDREN UNDER 18	MARRIED? DIVORCED? SEPARATED

Are all of your children/grandchildren in good health? yes_____ no______

Do any of your children/grandchildren have special needs? yes _____ no ____
Please explain: ____

Are any of your children/grandchildren receiving SSI or other form of government entitlement? yes_____ no______

If so, which entitlement are they receiving? ___________________________________

____

Are any of your children/grandchildren financially irresponsible?____________________

____

Do any of your children/grandchildren have an estate of more than $1 million?_________

____

Do you have any predeceased children? yes _____ no _____

If so, please indicate if they had any surviving children? yes ____ no______

PART C: HEALTH INFORMATION

HEALTH INSURANCE

MEDICARE A: yes ___ no ____

MEDICARE B: yes ___ no ____

MEDICARE HMO: yes ___ no ____

MEDICARE D: yes ___ no ____
Plan Name: ____

MEDICAID: yes ___ no ____

MEDIGAP INSURANCE: yes ___ no ____
Name of Insurance Company: ____

PRIVATE INSURANCE: yes ___ no ____
Name of Insurance Company: ____

LONG TERM CARE INSURANCE: yes ___ no ____

Name of Insurance Company: ____

PHARMACEUTICAL PLANS: yes ___ no ____

Name: ____

PHYSICIANS: ____

____

Approximately what are your monthly medical expenses? ____________________________

____

Are you currently receiving benefits under EPIC? yes_____ no______

If you're a veteran, are you currently receiving prescription benefits from the Veteran's Administration? yes_____ no______

Do you wish to be an organ donor? yes_____ no______

Do you want a living will prepared telling your physician not to prolong your life by artificial means? yes_____ no______

PART D: FINANCIAL INFORMATION

Financial Advisor: Name and Telephone Number: ________________________________

____

Accountant: Name and Telephone Number: ______________________________________

____

Average monthly expenses: (estimate)

Rent or mortgage: _________________ Real Estate Taxes: ______________
Homeowner's insurance: ____________ Food: _________________________
Caretaker expense: _________________ Car Expenses: __________________
Medical expenses including premiums: __________________________________
Utilities: _________________________ Entertainment:___________________
Other: ____________________________ _____________________________

PART E: MONTHLY INCOME

Net Salary or Wages	
Social Security Benefits	
Retirement Benefits	
Interest	
Dividends	
VA/Disability Benefits	
Rental Income	
Annuity Income	
Other	
TOTAL INCOME	

If there is a pension, please list the gross monthly pension amount and the name of the company or governmental entity paying the pension.

Gross Amount: $______________________

Name of Company or Governmental Agency: ___________________________________

____

Is there a death benefit? yes_____ no_____

Is your Social Security check direct deposit? yes____ no____

If so, with which institution?

____

PART F: ASSETS

PLEASE PROVIDE:

- **Description of asset**
- **Name of institution**
- **Value for each asset**
- **Title on account (sole name or joint with another)**

ASSETS **Beneficiary (if applicable)**

ASSETS	Beneficiary (if applicable)
AUTOMOBILES:	
CHECKING ACCOUNTS:	
PRIMARY RESIDENCE: Purchase Date:	

Amount Paid: Current Value: Value of Improvements: Balance on Mortgage: Intend to sell? (y/n) Veteran's Exemptions: (y/n) Senior Citizen's Exemptions: (y/n) STAR/Enhanced STAR Exemptions: (y/n)	
BUSINESS INTERESTS:	
INVESTMENT ACCOUNTS:	
MONEY MARKET ACCOUNTS:	

CERTIFICATES OF DEPOSIT:	
ANNUITIES:	
STOCK/MUTUAL FUNDS:	
RETIREMENT ACCOUNTS: (IRA; 401K; 403 (B); KEOGH; SEP)	

OTHER REAL ESTATE	
IRAs	
BONDS/BOND FUNDS	
LIFE INSURANCE (include type, face, value, cash value, & beneficiaries)	
OTHER (i.e. copyrights, patents, mineral rights, mortgages owned by you, jewelry, artwork, collections)	
TOTALS	

Do you have a safe deposit box? yes_____ no______

If so, where is it located? ____

Under whose name(s)? ____

Have you considered Long Term Care Insurance to cover the cost if you were in a nursing home?

yes____ no_______

ADDRESS OF ANY REAL PROPERTY OTHER THAN PRIMARY:

Street Address: ____

City: ____

State, Zip Code: ____

BURIAL:

Is it your wish to be buried or cremated? buried _____ cremated_____

Do you own a burial plot? yes _____ no _____

Burial Plot: Location: ____

Do you have an Irrevocable Burial Fund Contract? yes _____ no _____

(If so, please provide a copy.)

Do you have a burial account? yes _____ no _____

PART G: OUTSTANDING DEBT

Name of Creditor and Amount of Debt: ____

PART H: MISCELLANEOUS

Do you have any other legal issues of which I should be aware? yes_____ no______

Please explain: ____

Do you have any of the following documents?

Living Will? yes_____no______

Health Care Proxy? yes_____no______

Power of Attorney? yes_____no______

Last Will & Testament? yes_____no______ Date____________

Trusts? yes_____no______

Do you have any pets? yes_____ no______

Would like to plan for them? yes_____ no______

PART I: IMPORTANT POINTS TO THINK ABOUT

(Important decisions to make and to think about before your appointment: Whom do you want to serve as your representative to handle the following matters? Please provide complete addresses and telephone numbers if not provided elsewhere in this questionnaire?)

Executor: (The person who carries out the terms of your will.) You may name more than one person.

Name and Address: ____

Alternate #1: ____

Alternate # 2: ____

Agent for Health Care Proxy: (The person who you would like to appoint to make health care decisions for you if you are unable to do so due to incapacity.) You may only name one person to act at a time. You may also name alternates.

Name, Address & Telephone: ____

Alternate #1: ____

Alternate #2: ____

Agent for Durable Power of Attorney: (The person who you would like to appoint to make financial and legal decisions for you in the event of your incapacity.) You may name more than one person to act at a time. You must decide whether they will act together or whether each may act separately.

Name and Address: ____

Alternate #1: ____

Alternate # 2: ____

Have you done any long term care planning? yes ____ no _____

Would you like to discuss ways to protect your assets from the cost of long term care? yes _____ no ______

Would you like to discuss Long Term Care Insurance? yes _____ no ______

Do you wish to be an organ donor? yes______ no_______

Do you want a living will prepared telling your physician not to prolong your life by artificial means?
yes______ no_______

PART J: REFERRAL

Who referred you to this office? ____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Name: ____

Date: ________________________

NOTES:____

____

____

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