ESTATE PLANNING QUESTIONNAIRE
(SINGLE INDIVIDUAL)

Thank you for considering Estate Planning & Elder Law Services, P.C. to assist you with the preparation of your estate planning documents. To maximize the effectiveness and efficiency of our first meeting together, we ask that you provide as much of the information sought in this form as possible. Your accuracy and completeness in responding will help us to best represent you in this matter. Please bring this information with you to our initial appointment.

A. PERSONAL DATA

Residence Information

Street Address:_____

City:_____ State:_____ Zip:_____ County:_____

Other states in which you have resided: _____

Biographical & Contact Information

Full Name:_____

Birth Date:_____

Social Security No.:_____

U.S. Citizen? ___ Yes ___ No

□ Home Phone:_____

□ Home E-mail:_____

□ Work Phone:_____

□ Work E-mail:_____

□ Work Fax:_____

□ Cell Phone:_____

Communicating with you: Check the box above for your preferred mode of communication.

B. HOW DID YOU HEAR ABOUT US?

□ Seminar/Community Ed._____(location) □ Postcard

□ Referred by: _____ □ Yellow pages

□ Search Engine: □ Google □ MSN □ Yahoo! □ Other _____

Have you visited our website **www.formyplan.com**? ___ Yes ___ No Please provide any suggestions. _____

C. CHILDREN & MARRIAGE(S) (include adopted children)

Child's Name	Date of Birth	Name of Other Parent	Parent that Child Lives With	# of Children (i.e., your grandchildren)

Have you ever been married? ___ Yes ___ No

If "yes" to the previous question, are you divorced from your former spouse(s), or is/are your former spouse(s) deceased? **Provide name(s) of former spouse(s) and date(s) of divorce(s) or death(s):**

_____

ATTACH COPY OR COPIES OF DIVORCE JUDGMENT(S)

Are all of your children in good health? ___ Yes ___ No
(If no, please describe the issue(s) and for which child(ren) such issue(s) apply)

_____

_____

Are any of your children blind? ___ Yes ___ No

(If yes, which child(ren)?) _____

Are any of your children disabled? ___ Yes ___ No
(If yes, please describe the disability and the child(ren) effected by such disability)

_____

_____

Are any of your children receiving SSI or other government benefits? ___ Yes ___ No
(If yes, please list the benefits and child(ren) receiving them)

_____

_____

Are any of your children deceased? ___ Yes ___ No
(If yes, please list the name(s) of the deceased child(ren) and the name(s) of their living child(ren), if any)

_____

_____

Have all of your children completed their educations? ___ Yes ___ No

Do any of your family members have any problems with:

____ Substance Abuse ____ Money Management ____ Other Problem

Please describe the nature of the problem(s). **(optional)**

_____

D. EXTENDED FAMILY

Your Parents

	Name	Age	Date of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____

Your Siblings (attach separate sheet if more than 2 siblings)

Name	Age	Date of Death	# of Children
_____	_____	_____	_____

_____ _____ _____ _____

E. MEDICAL HISTORY

1. Medical Conditions Have you been diagnosed with any of the conditions below?

Dementia	☐ Yes ☐ No	*Heart Attack*	☐ Yes ☐ No
Alzheimer's	☐ Yes ☐ No	*Heart Issues*	☐ Yes ☐ No
Parkinson's	☐ Yes ☐ No	*ALS*	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	*Other*	☐ Yes ☐ No
Stroke	☐ Yes ☐ No		

2. **Described Your Overall Condition**

_____

_____

F. MILITARY SERVICE HISTORY

Your Information	**Deceased Spouse's Information**
Veteran ___ Yes ___ No	Veteran? ___ Yes ___ No
Period of Service _____ -_____	Period of Service _____ -_____
Wartime Service ___ Yes ___ No	Wartime Service ___ Yes ___ No
Service Disability ___ Yes ___ No	Service Disability ___ Yes ___ No

G. FINANCIAL SUMMARY (Provide statements, titles, deeds, etc. for assets marked *)

1. Income

Your Employer:_____ Annual Income: $_____

2. Assets (check box if owned jointly with other individual(s))

	Current Value	**Joint**	**With Whom**
Checking Accounts *	$_____	☐	_____

Savings Accounts *	$_____	□	_____
Real Estate (residence) *	$_____	□	_____
Real Estate (other) *	$_____	□	_____
	$_____	□	_____
Certificates of Deposit *	$_____	□	_____
Money Market Accounts *	$_____	□	_____
Stocks - (Not Held by Broker)	$_____	□	_____
Stocks - (Held by Broker) *	$_____	□	_____
Bonds - (Not Held by Broker)	$_____	□	_____
Bonds - (Held by Broker) *	$_____	□	_____
Mutual Funds *	$_____	□	_____
Notes and Mortgages Receivable *	$_____	□	_____
Business Interests	$_____	□	_____
Expected Inheritances	$_____		
Automobiles *	$_____		
Jewelry & Collections	$_____		
Non-IRA Qualified Retirement Plans *	$_____		
IRAs *	$_____		
Life Insurance *	$_____		
Annuities *	$_____		
Other Assets	$_____		
TOTALS	$_____		

3. **Liabilities** (check box if debt is joint with other individual(s))

	Current Balance	**Joint**	**With Whom**

Notes Payable on Real Estate (i.e., mortgages)	$_____	□	_____
Other Loans Payable (e.g., home equity, etc.)	$_____	□	_____
Credit Card Debt [only if substantial, and not paid regularly]	$_____	□	_____
Other Miscellaneous Debt [only if substantial]	$_____	□	_____
TOTALS	$_____		

H. GENERAL ESTATE PLANNING GOALS

Following are a list of general estate planning goals. Please circle the numbers that best indicate the relative importance of each goal **(1 = Not Important; 10 = Very Important)**.

1. Avoid the probate court.

   1 2 3 4 5 6 7 8 9 10

2. Minimize or eliminate taxes (i.e. - gift, capital gains, estate, etc).

   1 2 3 4 5 6 7 8 9 10

3. Control your assets and affairs during any period(s) of disability.

   1 2 3 4 5 6 7 8 9 10

4. Provide for management and distribution of your assets at and/or beyond your death.

   1 2 3 4 5 6 7 8 9 10

5. Provide resources and the management of them for minor or disabled child(ren).

   1 2 3 4 5 6 7 8 9 10

6. Provide resources and the management of them for any children from previous marriages.

   1 2 3 4 5 6 7 8 9 10

7. Protect your assets from either current or anticipated long-term care costs.

   1 2 3 4 5 6 7 8 9 10

I. FINANCIAL DECISION MAKERS

Please choose your Financial Decision Maker(s). This is/are the person(s) who will

handle your financial affairs on your behalf during any period(s) that you cannot act for yourself (e.g., incapacity and death).

First Choice: _____ Date of Birth: _____

Second Choice:_____ Date of Birth: _____

Third Choice: _____ Date of Birth: _____

J. MEDICAL DECISION MAKERS

Please choose your Medical Decision Maker(s). This is/are the person(s) who will handle your medical and mental health affairs on your behalf during any period(s) that you cannot act for yourself (e.g., incapacity and death).

First Choice: _____ Date of Birth: _____

Second Choice:_____ Date of Birth: _____

Third Choice: _____ Date of Birth: _____

Please indicate which **one** of the following statements reflect your preference:

☐ I want my life prolonged to the greatest extent possible without regard to my-condition, the chances I have for recovery, or the cost of the procedures; **or**

☐ I want my life prolonged and I want life-sustaining treatment to be provided or continued **unless** I am in a coma or persistent vegetative state that my physician(s) believes to be irreversible in accordance with reasonable medical standards at that time, under which circumstances I want all life-sustaining treatment to be withheld or discontinued.

Do you have any objection to receiving blood transfusions? ___ Yes ___ No

Do you have any objection to being resuscitated? ___ Yes ___ No

Do you want to donate your organs? ___ Yes ___ No If so, describe the extent of your wishes:

___ All organs ___ Specific organ(s):_____

___ As determined by my Medical Decision Maker ___ Not for anatomical study

K. CHILD CAREGIVER(s) (Financial)

If you have **minor** or **disabled** child(ren), please choose who you want to act as Financial Decision Maker(s) over any assets that may belong to such child(ren)? *****

First Choice:_____ Date of Birth:_____

Second Choice:_____ Date of Birth:_____

L. CHILD CAREGIVER(s) (Medical)

If you have **minor** or **disabled** child(ren), please choose who you want to be in charge of making medical and other health care decisions on behalf of such child(ren)? *****

First Choice:_____ Date of Birth:_____

Second Choice:_____ Date of Birth:_____

*** Note: The financial and medical decision makers that you name in two sections above would only act in the event that your former spouse(s) are unavailable and/or unfit to act in such capacities.**

M. MISCELLANEOUS

Which, if any, estate planning document do you already have and when were they prepared?

□ Will(s) □ Trust(s) □ Medical Power(s) of Attorney □ Financial Power(s) of Attorney

ATTACH COPIES OF THESE DOCUMENTS OR BRING THEM WITH YOU

Do you have a Safe Deposit Box?
___ Yes ___ No

Have you ever made substantial gifts to anyone (i.e., in excess of $2,500.00)?
___ Yes ___ No

Have you ever filed a Federal Gift Tax Return (IRS Form 709)?
___ Yes ___ No

Do you have any other legal issues that we should be aware of? If so, please explain:

_____

N. DISTRIBUTION INTENTIONS

Please describe how you would like your assets to pass at your death. Complete these sections to the best of your ability. We will discuss your distribution intentions in greater detail at your initial meeting.

1. **Specific Gifts.** These are items of personal property, cash, or other specifically identified assets that you wish to give to named recipients. For example, you may wish to give your coin collection to your son, your wedding ring to your daughter, etc.

a. Do you wish to make gifts of specific items? **(If yes, list below or attach separate sheets if additional space is needed)**

Item (Describe)	**Recipient**
_____	_____
_____	_____

b. Do you wish to make cash gifts? **(If yes, list below or attach separate sheets if additional space is needed)**

Amount	**Recipient**
_____	_____
_____	_____

2. **Residue.** This is the balance of your assets not gifted under ¶1 above. For example, you may wish to distribute your assets to your surviving children in equal shares, to other family members, to charities, or a combination of any or all of these categories of beneficiaries.

How do you wish to distribute the residue of your estate at your death? (**Attach separate sheets if additional space is needed)**

_____

_____

_____

3. **Retirement Account Distributions.** Regarding post death distributions from your retirement accounts (e.g., IRA's, 401(k)'s, etc.), which of the following objectives is more important to you?

□ Maintaining post death restrictions (i.e., ages limits) on the distributions to beneficiaries (e.g., for a child's or a grandchild's share); or

□ Maximizing income tax deferral on the distributions taken by the beneficiaries.

O. CERTIFICATION

The information contained in this Estate Planning Questionnaire is accurate and complete to the best of my knowledge, information, and belief, and I understand that the law firm and its individual lawyers will rely upon this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

_____ _____

Signature Date