JULIAN GRAY ASSOCIATES
ELDER LAW ♦ ESTATE & DISABILITY PLANNING
AVOID MISTAKES. PROTECT ASSETS.

SETTLEMENT PLANNING QUESTIONNAIRE (Single)

(PLEASE COMPLETE THIS PACKET IN INK)

This information packet must be returned to us at least three days prior to your meeting (this will ensure we have enough time to understand the specifics of your situation before our meeting). If you need assistance completing the information, call our Client Relations Manager, Courtney Bachik, at (412-458-6000).

DON'T WORRY ABOUT TOTAL ACCURACY – JUST DO THE BEST YOU CAN

WE LOOK FORWARD TO SEEING YOU!!!

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

Julian Gray Associates
954 Greentree Road
Pittsburgh, PA 15220
Phone: 412-458-6000
Fax: 412-458-6015

www.GrayElderLaw.com

SETTLEMENT PLANNING QUESTIONNAIRE (Single)

PLEASE BE AWARE no attorney-client relationship has been formed by completing or not completing this questionnaire.

Date _____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.

A. PENDING CASE INFORMATION

Personal Injury Plaintiff Attorney Name _____

Plaintiff Attorney's Assistant/Paralegal Name _____

Plaintiff Attorney Firm Name _____

Plaintiff Attorney Phone No. _____

Workers' Comp Attorney Name _____

Workers' Comp Attorney's Assistant/Paralegal Name _____

Workers' Comp Attorney Firm Name _____

Workers' Comp Attorney Phone No. _____

Type of Claim ☐ Personal Injury ☐ Med Mal ☐ Wrongful Death ☐ Workers' Comp

Date of Loss _____ _____

State of Claim _____ County of Claim _____

Defendant Name(s) _____

Have you or will you be receiving a settlement from a law suit? ☐ Yes ☐ No

If yes, amount of settlement $_____

Health Insurance Carrier _____

Insurance Claim Number _____

Insurance Card Number _____

B. PERSONAL DATA (Disabled Individual)

Full Name _____

Street Address _____

City _____ County _____ State _____ Zip_____

Home Phone No. _____ Cell Phone No. _____

E-mail address _____

Birth Date _____ Social Security No. _____

U.S. Citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

No If Yes, Date of Discharge*: _____
If available, please return a copy of military discharge papers with this questionnaire.

Annual Income _____

Do you have a legal guardian? ☐ Yes ☐ No

Your Medical diagnosis is: _____

Your treating physician: _____

Are you employed? ☐ Yes ☐ No

Monthly income from employment: $_____

Are you receiving public benefits? ☐ Yes ☐ No

Monthly income from public benefits: $_____

The public benefits you are receiving or are likely to apply for are:

☐ SSI ☐ Medicaid ☐ SSD

☐ Medicare ☐ Medicaid Waiver ☐ Section 8 Housing

☐ Group Home ☐ Psychiatric ☐ Institutionalization

☐ Other Public Benefits _____

Is there a case worker involved? ☐ Yes ☐ No

Name and phone of caseworker: _____

If you are not receiving public benefits, has there been a determination of disability by the Social Security Administration? ☐ Yes ☐ No

Are the assets to fund the trust the assets of a parent or other third party? ☐ Yes ☐ No

If anticipating use of a Trust, the Trustee will be a: ☐Family member ☐Professional Trustee

C. ESTATE PLANNING DOCUMENTS

Do you have any of the following estate planning documents:

☐ Will
☐ Health Care Power of Attorney
☐ Revocable Trust
☐ Living Will
☐ Financial Power of Attorney
☐ Irrevocable Trust

D. PARENTS

(Husband) (Wife)

Full Name _____ Full Name_____

Street Address _____

City _____ County _____ State _____ Zip _____

Telephone Number _____ Email _____

(Husband) (Wife)

Birth Date _____ Birth Date _____

Social Security No. _____ Social Security No. _____

U.S. Citizen? ☐ Yes ☐ No U.S. Citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No Veteran? ☐ Yes ☐ No

Date of Discharge _____ Date of Discharge _____

E. **<u>CHILDREN</u>** (if applicable, including adult children)

Check this box if you have No living Children (adult or minor). ☐

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Email Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Email Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ Email Address _____

Date of Birth _____ Married? _____ Children? _____

Are any of your children disabled? Yes ☐ No ☐

Are any of your children receiving government benefits such as Social Security disability, SSI, Medicaid or Veteran's Benefits? If so, please specify. Yes _____ No

Do any of your family members have any problems with:

Drug Addiction	Yes	☐	No	☐
Alcoholism	Yes	☐	No	☐
Spendthrift	Yes	☐	No	☐

Do any of your children live with you in your home? Yes ☐ No ☐

If yes, name of child _____

Is anyone in your immediate or extended family disabled (including any spouses of your children): Yes ☐ No ☐

If yes, name of disabled family member _____

F. MISCELLANEOUS

Do you have any other legal issues which we should be aware of ? ☐ Yes ☐ No

If yes, please explain _____

_____

G. REFERRAL

By whom were you referred to this office? _____

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Telephone No. _____ E-mail address _____

Referral is a: ☐ Attorney ☐ Insurance Broker ☐ Trust Company ☐ Financial Advisor

☐ Disability Organization ☐ Other _____

H. CERTIFICATION

The undersigned hereby represents to Julian Gray Associates, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on 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 of Client or Client Representative:

_____

Although reasonable value approximations are acceptable, it is important to be certain of the identity of all assets and how they are owned or titled. This Questionnaire provides for identification of assets as owned solely, or as co-owned (with another person).

ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space.

ASSETS	SELF	JOINTLY HELD FUNDS	LIABILITIES
Personal Effects/Household Items	$		
Automobile	$		
Checking Account	$		
Savings Account	$		
Money Market Account	$		
Certificates of Deposit	$		
Residence (Assessed Value) Block #_____ Lot #_____ (Obtain from Tax Bill)	$		
Other Real Estate	$		
Additional Automobiles	$		
Mutual Funds	$		
Stocks	$		
Bonds	$		
Annuities	$		
Cash Value - Life Insurance	$		
IRA	$		
Nursing Home Deposit	$		
Other	$		
Other	$		
TOTALS	$		

What did you pay for your current home including any improvements? $_____

Do you own any real property other than personal residence? _____