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PROVIDING:
ELDER LAW SERVICES
ESTATE PLANNING AND TRUST ADMINISTRATION
MEDICAID AND PUBLIC BENEFITS PLANNING
SPECIAL NEEDS PLANNING
GUARDIANSHIP SERVICES
WILL CONTESTS AND PROBATE LITIGATION
NURSING HOME LAW AND LITIGATION
VA BENEFITS PLANNING
FAMILY LAW SERVICES
COLLABORATIVE LAW
MEDIATION SERVICES
SOCIAL SECURITY DISABILITY APPEALS

CONFIDENTIAL CLIENT QUESTIONNAIRE
for
ESTATE, ENTITLEMENT AND ASSET PROTECTION PLANNING

This questionnaire is intended to elicit the basic information we need to help you with estate and public benefits planning. The more complete and accurate your responses, the better we will be able to help you. Please bring the completed form with you to our first meeting, along with the following documents, if available: estate documents (wills, trusts, etc.), financial statements, last year's tax returns, insurance policies, deeds, divorce decrees, prenuptial agreements, and guardianship documents. **All information will be held in the strictest confidence.**

Today's Date _____

1. Name of Person Completing Questionnaire: _____

Address: _____

Tel. Home: _____ Tel. Bus: _____

Cell Phone No. _____ E-mail Address: _____

Fax: _____Your Relationship to Elder: _____

_____

Purpose of This Visit? _____

PART A: REFERRAL

By whom were you referred to this office?
Name _____
Street Address_____
City_____ State_____ Zip_____

Referral is:
___ Attorney
___ Financial Planner
___ Previous Client of the Law Office of Donald D. Vanarelli
___ Website
___ Other_____
Have you visited our website at www.dvanarelli.com? Yes ☐ No ☐
If yes, do you have any ideas for improving our website? If so, please discuss.
_____

PART B: PERSONAL INFORMATION

3. **Husband**

Name: _____
Address: _____
_____
Phone: _____
Email: _____
Date of birth: _____
SSN: _____
Driver's License No. and Name of Issuing State: _____
U. S. citizen?: ☐ Yes ☐ No
Veteran?: ☐ Yes ☐ No

4. **Wife**

Name: _____
Address: ☐ Same as Husband
☐ Different: _____
Phone: _____
Email: _____
Date of birth: _____
SSN: _____
Driver's License No. and Name of Issuing State: _____
U. S. citizen?: ☐ Yes ☐ No
Veteran?: ☐ Yes ☐ No

5. Date and place of marriage:_____

6. Who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?: _____
_____

PART C: MEDICAL INFORMATION

7. Name of Ill Spouse: _____

Diagnosis: _____ Prognosis: _____

8. Name of Well Spouse: _____

Health of Well Spouse: _____

PART D: LIVING ARRANGEMENTS

Husband:

9.	**Place Where You Live**	**Since When?**
☐	Single-family home	
☐	Same, but someone assists you there	
☐	Apartment or retirement living community	
☐	Assisted-living facility	
☐	Nursing home	
☐	Other:	

10. List the names of all persons who provide assistance to or caregiving for you:
_____
_____

11. Does a child, parent, sibling, or other family member currently live in your home? Yes ☐ No ☐ If yes, identify who lives with you, how long they have lived with you, and whether they own any part of your home: _____
_____

12. If you answered yes to the question above, is any portion of your income used to provide all or a portion of their support? Yes ☐ No ☐.

Wife:

13.	**Place Where You Live**	**Since When?**
☐	Single-family home	
☐	Same, but someone assists you there	
☐	Apartment or retirement living community	
☐	Assisted-living facility	
☐	Nursing home	
☐	Other:	

14. List the names of all persons who provide assistance to or caregiving for you:
_____
_____

15. Does a child, parent, sibling, or other family member currently live in your home? Yes ☐ No ☐ If yes, identify who lives with you, how long they have lived with you, and whether they own any part of your home: _____
_____

16. If you answered yes to the question above, is any portion of your income income used to provide all or a portion of their support? Yes ☐ No ☐.

Couple:

17. If either spouse is in a nursing home, please provide the name and address of the nursing home and the admission date: _____

Monthly Cost _____ Funding Source(s) _____
The nursing home is paid through _____ (month/year).

18. Were you or your spouse admitted to a hospital or other medical institution immediately prior to your admission to the nursing home? Yes ☐ No ☐. If yes, please provide the name and address of the institution and the admission date: _____

_____

PART E: FAMILY MEMBERS

19. **CHILDREN**

(Include children who predeceased you, if any.)

Name	Address	Age	Sex	Telephone Number	Spouse's Name

Relationship: ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Child born out of wedlock

20. **GRANDCHILDREN**

Name	Address/Parent Name	Age	Sex	Marital Status	Spouse's Name

21. Are all your children / grandchildren in good health? Yes ☐ No ☐
22. Are any of your children / grandchildren blind? Yes ☐ No ☐
23. Are any of your children / grandchildren disabled? Yes ☐ No ☐

24. Do any of your children / grandchildren receive SSI, Medicaid or other government benefits based upon financial need? Yes ☐ No ☐

25. Do you or any of your family members have any problems with:

AIDS?	Yes ☐ No ☐	Drug Addiction?	Yes ☐ No ☐
Alcoholism?	Yes ☐ No ☐	Spendthrift?	Yes ☐ No ☐
Marital Difficulty?	Yes ☐ No ☐		

26. Do you trust your children's spouses? Yes ☐ No ☐

27. Are you concerned about potential litigation against you? Yes ☐ No ☐

PART F: MONTHLY INCOME

28. Source of Income	Husband	Wife
Gross Salary or Wages	_____	_____
Social Security (include Medicare Part B Premiums)	_____	_____
Retirement Benefits	_____	_____
Interest	_____	_____
Dividends	_____	_____
Veterans' Benefits	_____	_____
Pension (Gross Amount)	_____	_____
Annuity	_____	_____
Alimony	_____	_____
Rental Income	_____	_____
Other	_____	_____
TOTAL INCOME	_____	_____

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PART G: ASSETS

29. REAL ESTATE (Please provide copies of current tax bills and deeds)

Street Address, City, State	Owner*	Fair Market Value	Assessed Value (Obtain from Tax Bill)	Outstanding Loans

*H=Husband, W=Wife, JT=Joint Tenant, TC=Tenants-in-Common

30. Homeowner's Insurance Company: _____

31. BANK ACCOUNTS (Attach separate sheet(s) if necessary)

Bank Name and Address	Type of Acct*	Account Number	Owner	Amount on Deposit

*Checking Account (CA), Savings Account (SA), Certificates of Deposit (CD), Money Market Accts (MMA)

32. IRAs, KEOUGHS, 401(K) RETIREMENT PLANS

Name and Address of Plan Custodian	Owner	Account Number	Primary/Alternate Beneficiary	Value

33. MUTUAL FUNDS (Please list all mutual funds and provide statements)

Company Name and Address	Owner	Account Number	Fair Market Value

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34. **STOCKS (Non-Mutual Funds; Do Not Include IRAs)**

Name of Stock	Owner	Number of Shares	Purchase Date	Cost	Current Market Value

35. **BONDS AND TREASURY NOTES (Non-Mutual Funds)**

List all US Savings Bonds, corporate bonds, municipal bonds, treasury notes, etc.	Owner	Face Value

36. **LIFE INSURANCE and ANNUITY CONTRACTS (Please provide copies)**

Company Name and Address	Owner	Cash Surrender Value/Death Benefit	Policy Number	Primary / Alternate Beneficiaries

37. **BUSINESS INTERESTS**

Company	Owner	Type*	Percentage Ownership	Value	Buy/Sell Agreement

*Corporation (C), Sole Proprietorship (SP), Partnership (P), Limited Liability Company (LLC)

38. **VALUABLE PERSONAL PROPERTY: AUTOMOBILES, JEWELRY, COLLECTIONS, ETC.**

ASSET	OWNER	VALUE

39. Do either you or your spouse expect to inherit significant property? Yes ☐ No ☐ . If yes, please explain: _____

40. Do either of you have a safe deposit box? Yes ☐ No ☐. If yes, provide the box number(s), location(s) and contents: _____

41. Do you or your spouse own any burial plots? Yes ☐ No ☐. If yes, please provide the name and address of the cemetery, and attach copies. _____

42. Have you or your spouse prepaid your funeral? Yes ☐ No ☐. If yes, please provide name and address of funeral home, and attach copies of funeral contract.

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43. **Public Benefits and Community Services**

In addition to Social Security and Medicare, are you receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, PAAD, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group services, property tax relief, home weatherization, and drug company discount card programs. ☐ Yes ☐ No If yes, please list them below:

Provider	**Form of assistance**

44. **DIGITAL ASSETS**

Do you or your spouse have any digital assets including the following:

☐ Security System--Primary Residence: Code: .....
☐ Security System--Vacation Residence: Code: .....
☐ Desktop computer: Username: ..... Password .....
☐ Laptop computer: Username ..... Password .....

☐ Email Accounts: ☐ Gmail ☐ Hotmail ☐ Outlook ☐ AOL ☐ [Other] .....

☐ Social Networking: ☐ Facebook ☐ LinkedIn ☐ Twitter ☐ Pinterest ☐ [Other] ...

☐ Telecommunications: ☐ Skype ☐ AOL AIM ☐ [Other] .....

☐ Digital Photography: ☐ Snapfish ☐ Shutterfly ☐ [Other] .....

☐ Credit Cards: ☐ Visa ☐ Mastercard ☐ American Espress ☐ [Other] .....

☐ E-commerce Accounts: ☐ PayPal ☐ eBay ☐ Craigslist ☐ Amazon ☐ Other]

☐ Website Domain Name, Address and Password: .....

☐ Other Online Accounts: ☐ Flickr ☐ YouTube ☐ [Other] .....

45. **DEBTS**

(Include real estate taxes, insurance, utilities, credit card debt, personal loans, lines of credit, informal loans from family members, etc. (Do not include the mortgages listed above.)

CREDITOR	AMOUNT	PROPERTY SECURED

46. Do you need to make improvements or repairs on your home? Yes ☐ No ☐. If yes, describe the improvements needed, and estimated costs: _____

47. Do you need a new car? Yes ☐ No ☐.

48. Do you need or want any household items or personal effects? Yes ☐ No ☐. If yes, set forth items and cost: _____

PART H: MONTHLY HOUSING EXPENSES

49. Please provide the following *monthly* housing expenses:

$ _____ Mortgage/Rent

$ _____ Real Estate Taxes

$ _____ Water

$ _____ Sewer

$ _____ Utilities (Heat, Electric & Telephone)

$ _____ Homeowner's Insurance Premium

$ _____ Condominium Fees

$ _____ **Monthly Total**

PART I: MONTHLY NON-SHELTER LIVING EXPENSES

50. Please provide the following *monthly* non-shelter living expenses:

$ _____ Food

$ _____ Medical

$ _____ Clothing

$ _____ Transportation (including auto insurance)

$ _____ Home Maintenance

$ _____ Life Insurance Premiums

$ _____ Health Insurance Premiums

$ _____ Cable TV

$ _____ Other

$ _____ **Monthly Total**

PART J: ESTATE DOCUMENTS

	Date Made	Location of Original
51. Last Will and Testament	_____	_____
Durable Power of Attorney	_____	_____
Living Will/Health Care Proxy	_____	_____
Trust Instruments	_____	_____

(Please provide copies of all estate documents identified above.)

52. I am the legal guardian of: _____

53. I have been appointed as agent under a power of attorney from: _____

Provide the information requested below <u>ONLY</u> if you do not have estate documents or you want to make changes to the documents in our planning process. If not, skip to Part K.

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54. YOUR LAST WILL AND TESTAMENT.

PRIMARY BENEFICIARIES.

Identify those persons to whom you want to leave your estate, and in what amounts.

Name	Address	Relationship	Percentage of Estate or Amount

Please explain any special medical or financial needs of any persons listed above _____

ALTERNATIVE BENEFICIARIES.

If the persons identified above as Primary Beneficiaries die before you, who do you want to inherit your estate instead?

Name	Address	Relationship	Percentage of Estate or Amount

Please explain any special medical or financial needs of any persons listed above:_____

SPECIFIC GIFTS.

Do you or your spouse wish to make any specific gifts of tangible personal property, real estate, cash, securities, etc?

Specific Gift	Name Of Beneficiary	Address	Relationship

CHARITIES YOU WISH TO BENEFIT.

Name of Charity	Address	Percentage of Estate or Amount

EXECUTORS.

Who do you want to be the executor of your estate? List alternates in case the person you name is unable or unwilling to serve.

Name	Address	Relationship	Age

TRUSTEES.

Who do you want to manage any trusts that are established? List alternates in case the person you name is unable to serve.

Name	Address	Relationship	Age

GUARDIANS.

Who do you want to designate as caretakers for people who are minors or incompetents? List alternatives in case the person you name is unable or unwilling to serve. You can designate people to serve together (e.g., husband and wife, etc.).

Name	Address	Relationship	Age

55. LIVING WILLS.

A living will and health care proxy address several important health care issues. These documents inform medical providers of your wishes concerning your care, and authorize someone, as your agent, to make health care decisions when you cannot do so. In addition to the information requested, you can add any personal matters of concern in the margins or on attached pages.

YOUR LIVING WILL INFORMATION

Doctor: (Name and Address) _____

Priest/Rabbi/Spiritual Advisor: (Name and Address) _____

Agents: _____

Medical procedures (When you have an incurable disease, are in a long-term coma or are severely demented): [ ] May be withheld [ ] Agent may decide [ ] May not be withheld [ ] Other: _____

Nutrition/Hydration: [ ] May be withheld [ ] May not be withheld [ ] Agent may decide [ ] Other: _____

Pain Medication/Treatment: [ ] Should be provided [ ] May be withheld [ ] Agent may decide [ ] Other: _____

Do you direct that all health care decisions made by your Agent on your behalf be consistent with the teachings of your religion or faith? [ ] Yes [ ] No If yes, please describe your religion: _____

Autopsy: [ ] May be performed [ ] May not be performed

Organ Donation: [ ] Yes [ ] No

Disposition of Remains: [ ] Cremation [ ] Funeral/Burial [ ] Agent May Decide
[ ] As described in my Will, funeral contract, or other
Specify: _____

Memorial Service: [ ] Yes, in accordance with _____ religion
[ ] Yes, with the following songs, readings, people, etc.
_____
[ ] No [ ] Other: _____

Euthanasia: [ ] Agree [ ] Disagree

Do Not Resuscitate Orders: [ ] May be established [ ] May not be established

Other Personal Preferences: _____

SPOUSE/PARTNER'S LIVING WILL INFORMATION

Doctor: (Name and Address) _____

Priest/Rabbi/Spiritual Advisor: (Name and Address) _____

Agents: _____

Medical procedures (When you have an incurable disease, are in a long-term coma or are severely demented): [ ] May be withheld [ ] Agent may decide [ ] May not be withheld [ ] Other: _____

Nutrition/Hydration: [ ] May be withheld [ ] May not be withheld
[ ] Agent may decide [ ] Other: _____

Pain Medication/Treatment: [ ] Should be provided [ ] May be withheld
[ ] Agent may decide [ ] Other: _____

Do you direct that all health care decisions made by your Agent on your behalf be consistent with the teachings of your religion or faith? [ ] Yes [ ] No If yes, please describe your religion:_____

Autopsy: [ ] May be performed [ ] May not be performed

Organ Donation: [ ] Yes [ ] No

Disposition of Remains: [ ] Cremation [ ] Funeral/Burial [ ] Agent May Decide
[ ] As described in my Will, funeral contract, or other
Specify: _____

Memorial Service: [ ] Yes, in accordance with _____ religion
[ ] Yes, with the following songs, readings, people, etc.
_____
[ ] No [ ] Other: _____

Euthanasia: [ ] Agree [ ] Disagree

Do Not Resuscitate Orders: [ ] May be established [ ] May not be established

Other Personal Preferences:_____

56. **POWER OF ATTORNEY.**

A power of attorney (POA) is a critical component of any estate plan. A POA provides authority to a designated person to manage your financial affairs on your behalf in the event you are disabled, or otherwise unable to act. Please indicate, in order, the names, addresses and relationships of persons to serve as your agents.

Name	Address	Relationship	Age

Answer the following questions as best you can. Add additional concerns in the margins:

Should agents have authority to act: [ ] Only if you are disabled (i.e., springing); or [ ] immediately (i.e., durable)?

Should multiple agents be required to act jointly? [ ] Yes [ ] No.

Should the last agent be given the authority to appoint a successor? [ ] Yes [ ] No

Should agents be given compensation? [ ] Yes [ ] No.

Should agents have power over retirement assets? [ ] Yes [ ] No.

Do you want your agent(s) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?: ☐ Yes ☐ No

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

☐ No restrictions, I trust my agent(s) to make the right decision.
☐ My restrictions are:_____

PART K: GIFTS

57. Have you or your spouse made any gifts or transfers in excess of $1,000/year to an individual other than your spouse within the past 60 months? Yes ☐ No ☐ If yes, please provide detthe following information:

Recipient_____ Date _____ Amount_____
Recipient_____ Date _____ Amount_____
Recipient_____ Date _____ Amount_____

Did you or your spouse ever file a federal gift tax return? Yes ☐ No ☐. If yes, please provide details: _____

58. **INSURANCE**

HUSBAND	**WIFE**
Medicare/Private Insurance **Yes ☐ No ☐** Company:_____	**Medicare/Private Insurance** **Yes ☐ No ☐** Company:_____
Address:_____	Address:_____
Other: Accident, Liability, Etc. **Yes ☐ No ☐** Company:_____	**Other: Accident, Liability, Etc.** **Yes ☐ No ☐** Company:_____
Address:_____	Address:_____

56. Do you own Long-Term Care Insurance (LTCI)? Yes ☐ No ☐ Have you considered LTCI to cover the catastropic costs of long-term care? Yes ☐ No ☐.
57. Do you believe there is any other information I should be aware of? Yes ☐ No ☐. If yes, please explain: _____

_____

_____

PART L: CERTIFICATION

I understand that the recommendations and advice which you give, and any documents you prepare, will be based on the accuracy and completeness of the disclosures made herein. **Thus, I certify that the information provided is true and correct in all respects to the best of my knowledge and belief.**

_____ _____

Client **Client**