



Planning questionnaire

Complete all items that apply to you. Call us if you need help.
Print names as they would appear on legal documents.

Date _____

Client name _____

Currently living: Home __Nursing home__ALF__

If in nursing home or ALF, previous address:

Home address _____

City _____ State _____ Zip _____

County _____

Telephone _____ E-mail _____

Social Security # _____

Date of birth _____

U.S. citizen: Yes _____ No _____

Resided in Florida since _____

Veteran: Yes _____ No _____

If someone other than client or spouse:

Contact person name _____

Address _____

Telephone _____

Email _____

Spouse name _____

Currently living: Home __Nursing home__ALF__

If in nursing home or ALF, previous address:

Home address _____

City _____ State _____ Zip _____

County _____

Telephone _____ E-mail _____

Social Security # _____

Date of birth _____

U.S. citizen: Yes _____ No _____

Resided in Florida since _____

Veteran: Yes _____ No _____

Date of marriage _____

If deceased, date of death _____

After completing the questionnaire, please sign the following statement.

Certification. I understand that it is my responsibility to disclose correct and complete information. I hereby attest that I have supplied complete and accurate information that can be relied on during the planning process and will report any changes as they occur.

Signature

Date

Health of Client

Current medical or health problems _____

Past medical or health problems _____

If the Client is not living at home:

Facility name _____ Date of admission _____

Address _____ City _____ State ____ Zip _____

County _____ Telephone _____ Covered by **Hospice?** Yes ___ No ___

Health of Spouse

Current medical or health problems _____

Past medical or health problems _____

If the Spouse is not living at home:

Facility name _____ Date of admission _____

Address _____ City _____ State ____ Zip _____

County _____ Telephone _____ Covered by **Hospice?** Yes ___ No ___

Nursing home/assisted living facility expenses

Complete this section only if applicable. Use back of page if both are in facilities.

Monthly facility charges	
Monthly drug expenses	
Facility paid through what date?	

Family members and others interested in your welfare

Please print all names as they would appear on legal documents.

Name _____ Relation to **Client** _____ Relation to **Spouse** _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relation to **Client** _____ Relation to **Spouse** _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relation to **Client** _____ Relation to **Spouse** _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relation to **Client** _____ Relation to **Spouse** _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relation to **Client** _____ Relation to **Spouse** _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Are any of your children of any age disabled?

Name _____ Relation to **Client** _____ Relation to **Spouse** _____
Date of birth _____ Receiving what public benefits? _____

Documents to provide with the completed questionnaire

- Last Will and Testament
- Trust and amendments
- Durable Power of Attorney
- Health Care Surrogate
- Living Will
- Other estate planning documents for client and/or spouse
- Driver's license for client and/or spouse.

Financial and legal advisors

Investment advisor name _____

Company name _____

Address _____

Telephone _____ E-mail _____

Accountant or CPA name _____

Company name _____

Address _____

Telephone _____ E-mail _____

Attorney name _____

Address _____

Telephone _____ E-mail _____

Who referred you to our office?

Name _____ Relationship _____

Address _____

Telephone _____ E-mail _____

Legal issues

Please describe any legal issues that I should be aware of: _____

Safe deposit box

Name of bank, bank branch, box # _____

Who is authorized to enter the box? _____

Monthly income summary

List all income. Gross income equals what is actually received plus any deductions. Social Security deductions may include Medicare Part B and Medicare Part D. Pension deductions may include taxes, health insurance, etc. Adjust any quarterly or yearly payments to a monthly amount.

Source	<u>Client</u> Gross income	<u>Client</u> Net income	<u>Spouse</u> Gross income	<u>Spouse</u> Net income
Social Security				
Pension				
IRA distributions				
Veteran's benefits				
Interest and dividends				
Rental income				
Other income Source:				
Total	\$	\$	\$	\$

Amount owed to creditors

Credit cards	
Mortgage	
Automobile loans	
Other – what?	

Bank accounts - checking, savings, money market, CDs, etc.

Please list information on all accounts. Use the back of this page for additional accounts.

Owner(s)	Type of account	Bank name	Balance
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
			\$
Total			\$

Retirement accounts - IRA, SEP, 401(k), profit sharing, Keogh, etc.

Please attach a copy of the most recent statement.

Owner	Company	Beneficiary(s)	Value	Distributions
			\$	\$
			\$	\$
			\$	\$
			\$	\$

Annuities

Please attach a copy of the most recent statement.

Owner	Company	Beneficiary(s)	Value	Payments
			\$	\$
			\$	\$
			\$	\$
			\$	\$

Home

Address _____

House ___ Mobile home ___ Condominium ___ Other, describe _____

If mobile home: Own the lot _____ Rent the lot _____ Stock ownership _____

Names on the deed _____

Is there a mortgage? Yes ___ No ___ Mortgage balance? \$ _____

Most recent tax assessor's value \$ _____

What price would you expect to receive if you sold the home? \$ _____

Date of purchase _____ Purchase price \$ _____

Homestead exemption on property _____

Monthly shelter expenses

Mortgage/Rent (Please circle which)	
Real estate taxes	
Homeowners/Renters insurance (Please circle which)	
Home maintenance and upkeep	
Utilities	
Condominium fees	
Total monthly shelter expenses	

Anticipated major repairs to home

Type of repair _____ Estimated cost _____

Type of repair _____ Estimated cost _____

Other real property

Property #1 Address _____

House ___ Mobile home ___ Condominium ___ Other, describe _____

If mobile home: Own the lot _____ Rent the lot _____ Stock ownership _____

Names on the deed _____

Is there a mortgage? Yes ___ No ___ Mortgage balance? \$ _____

Most recent tax assessor's value \$ _____

What price would you expect to receive if you sold the home? \$ _____

Date of purchase _____ Purchase price \$ _____

Do you receive rental income? Yes ___ No ___ Monthly rental amount \$ _____

Provide information about additional property on the back of this page.

Money due to you - Loans, mortgages, promissory notes, etc.

Name(s) on the note or mortgage _____

Balance due: \$ _____

Can the mortgage be sold? Yes _____ No _____

Amount you could sell it for? \$ _____

Provide information about additional loans or notes owed to you on the back of this page.

Life insurance

Company	Insured/Owner if different, list both	Beneficiary(s)	Face value	Loan amount	Cash value
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

Vehicles including cars, boats, RVs, etc.

Type	Year	Make/model	Owner(s)	Value

Burial assets

Name and address of cemetery and number of cemetery plots _____

Burial contracts or pre-paid funeral agreements

Contract #1 Name of owner _____
Name, city, state of funeral home _____
Contract is: revocable _____ irrevocable _____ Contract amount \$ _____

Contract #2 Name of owner _____
Name, city, state of funeral home _____
Contract is: revocable _____ irrevocable _____ Contract amount \$ _____

Special burial bank account

Name of bank _____ Names on account _____ Balance \$ _____

Gifts to someone other than spouse within past 36 months

Please provide information on all gifts of any amount made to a person other than spouse on or after November 1, 2007, and for gifts in excess of \$5,000 for the three years prior to November 1, 2007.. Use the back of the page for additional gifts in the past 36 months.

Type of asset = cash, savings bonds, CD, stock, automobile, real estate, etc.

Type of asset _____ Value of asset \$ _____

Date of gift _____

Who was given the asset _____

Type of asset _____ Value of asset \$ _____

Date of gift _____

Who was given the asset _____

Type of asset _____ Value of asset \$ _____

Date of gift _____

Who was given the asset _____

Type of asset _____ Value of asset \$ _____

Date of gift _____

Who was given the asset _____

Type of asset _____ Value of asset \$ _____

Date of gift _____

Who was given the asset _____

Health insurance

Client. Please complete all that apply.

Medicare

(From Medicare card) Medicare number _____ Effective date _____

_____ Medicare traditional fee for service: Part A _____ Part B _____ Part B premium _____

_____ Medicare HMO: Company name _____ Premium _____

_____ Medicare supplement: Company _____ Premium _____

Supplement paid for by: Individual _____ Pension deduction _____ Other _____

_____ Medicare Part D drug benefit: Company _____ Premium _____

Part D paid for by: Individual _____ Social Security deduction _____ Other _____

Long term care insurance Company _____ Premium _____

Benefit description _____

Other insurance Type _____

Company _____ Premium _____

Spouse. Please complete all that apply.

Medicare

(From Medicare card) Medicare number _____ Effective date _____

_____ Medicare traditional fee for service: Part A _____ Part B _____ Part B premium _____

_____ Medicare HMO: Company name _____ Premium _____

_____ Medicare supplement: Company _____ Premium _____

Supplement paid for by: Individual _____ Pension deduction _____ Other _____

_____ Medicare Part D drug benefit: Company _____ Premium _____

Part D paid for by: Individual _____ Social Security deduction _____ Other _____

Long term care insurance Company _____ Premium _____

Benefit description _____

Other insurance Type _____

Company _____ Premium _____

ACTIVITIES OF DAILY LIVING FOR CLIENT

Activity	Needs no help	Needs some help	Unable to do at all
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using toilet			
Grooming			
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

ACTIVITIES OF DAILY LIVING FOR SPOUSE

Activity	Needs no help	Needs some help	Unable to do at all
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using toilet			
Grooming			
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			