Estate & Financial Information Questionnaire

Date: ___________________

Person supplying answers to these questions:

☐ Client ☐ Other (Relationship: ____________________)

If other: Name ____

Address: ____

Phone-Day: _____________________Night: ___________________Mobile: ___________________

Fax: ______________________________ Email: _____________________________________

Client Name: (First, Middle & Last)	
Date of Birth:	**Social Security No:**
Home Address:	
County:	**Email:**
Phone (Home):	**Phone (Work):**
Phone (Mobile):	**Fax:**
Mailing Address (if different from above):	
Living Arrangements: ☐ Owner Occupied: ☐ Rented Home or Apartment: ☐ With Relatives: ☐ Group Home or ICF-MR Facility: ☐ Assisted Living Facility: ☐ Nursing Home: **Who else lives there (if not institution):**	
Citizenship: ☐ U.S. ☐ Resident Alein ☐ Neither	
Marital History: ☐ Never Married ☐ Widowed Date of Death ______________________ ☐ Divorced Date of Divorce: ________________ County of Divorce: _____________________ Name(s) of previous spouse(s): ______________________________________	

Your Family

Do you have one or more living children? ☐ Yes ☐ No
Do you have any grandchildren who are children of a deceased child of yours? ☐ Yes ☐ No
Do you know of a person with a disability to whom you might consider making gifts?
☐ Yes ☐ No If so, name: ____

List below your children. If a child of yours has died, also list his or her children (your grandchildren):

Full Name	Address	Phones	Disabled?[2]	Age
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐ Uncertain	
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐ Uncertain	
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐ Uncertain	
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐ Uncertain	
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐ Uncertain	
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐ Uncertain	
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐ Uncertain	

Who now is providing significant assistance to you?
☐ Nobody ☐Name(s): ____
Address & phone, if not provided above: ______________________________________
____

Attorney use only:
Notes regarding family and other sources of support, conflict or difficulty
____
____

[2] A person is "disabled" for this purpose if he or she is unable, due to physical or mental disability, to engage in substantial gainful employment that exists in significant numbers in the national economy. If the person is presently receiving Social Security Disability, Supplemental Security Income (SSI), or Medicaid assistance for long term care, he or she does meet this requirement.

Nursing Home/Hospital Information (if applicable)

Please include all nursing homes, hospitals and rehabilitation facilities utilized for the same spell of illness or injury as that currently in treatment (if any)

Date In	Date Out	Name of Facility (&place if not Houston)	NH	Hosp	Rehab

If you are in a nursing home now–Is Medicare paying for your nursing home stay now? ☐Yes ☐ No

Anticipated Future Need for Long Term Care				Life Expectancy
Hospital:	☐> 6mos	☐1-6 ms.	☐<1 mo.	☐ No Know Limit
Nursing Home:	☐> 6 mos	☐1-6 ms.	☐<1 mo.	☐ Less than 6 months according to Dr.
Assisted Living:	☐> 6 mos	☐1-6 ms.	☐<1 mo.	☐ Uncertain whether limited
Home Care:	☐> 6 mos	☐1-6 ms.	☐<1 mo.	☐ Other: ______________________________

Your Health

Diagnoses: ____

____

____

Medication(s): ____

____

____**Nursing help you are getting now:** ____

____

____

Activities you need help with (check all that apply):

☐ Dressing ☐ Bathing ☐ Toileting ☐ Transferring

☐ Eating ☐ Continence ☐ Medications ☐ Walking

Known limitation on life expectancy?

☐ Yes ☐ No If Yes, please explain: ____

____

Mental Status (Check all that apply, even if only from time to time):

Recognize friends & family: ☐ Yes ☐ No ☐ Sometimes

Can describe own money & property: ☐ Yes ☐ No ☐ Sometimes

Can name all close family members: ☐ Yes ☐ No ☐ Sometimes

Comments: ____

____

Your Medical Expenses

Medical Expense	Cost/Month
☐ Nursing Home ☐ Assisted Living Facility ☐ Home Care ☐ Sitter	
Medications (out of pocket expense):	
☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D	
Medicare Supplement Insurance Company Medicare Advantage Plan:	
☐ Other Medical Insurance Type: ___________________________________ Company: ____	
☐ Long Term Care Insurance:	
Other out of pocket Medical Expenses:	

Military Service

Have you or your spouse ever been in the armed forces? ☐ YES ☐ NO

Veteran's Name	Service No./Branch	Dates of Service	Type of Discharge*
			H ☐ G ☐ D ☐
			H ☐ G ☐ D ☐
			H ☐ G ☐ D ☐

***H=Honorable G=General D=Dishonorable**

Information Concerning your residence, if owned by you:

Deed is in the name of

☐ You alone (100% ownership)

☐ You and ____, and you own ______% of the residence. Relationship, if any, of co-owner(s): ______________________________________

____

Estimated fair market value (tax appraised value if known): $ _________________________

Amount owed on the mortgage: ☐ Nothing (paid off) ☐ Presently owe $_________________

Location: ____

Who lives there now?

☐ You alone

☐ You and ______________________________ Relationship: __________________________☐ Renters paying $ _______ Per month

☐ Persons not paying rent: __________________________ Relationship: ___________________

Does unmarried son or daughter live there ? ☐ Yes ☐ No

Does a son or daughter who has provided care for your for 2 years live there ? ☐ Yes ☐ No

Other information concerning the residence that may be important:

____

Your Other Assets

Resource Description	**Value**
Most Valuable Vehicle[1]:	
Vehicle 2:	
Gravesite/Marker(s): (Name of Cemetery):	
Prepaid Funeral Contracts:	
Prepaid Funeral Goods:	
Household Goods:	
Checking Accounts (Name(s) of Bank(s) or Credit Union(s)):	
Savings ***not*** in IRA's (Name(s) of Bank(s) or Credit Union(s)):	
CD's ***not*** in IRA's (Name(s) of Bank(s) or Credit Union(s)):	
Money Markets ***not*** in IRA's (Name(s) of Bank(s) or Credit Union(s)):	
Stocks/Bonds ***not*** in IRA's (Brokerage or Security Name):	

[1]Enter year, make, model for all vehicles. Include any motorcycles, boats, trailers or RVs.

Resource Description	Value
Untaxed Retirement Accounts (such as 401K's IRA's & "Qualified" Annuities) Company Name:	
Tax-Deferred (Non-qualified) Annuities Company Name:	
Safe Deposit Box, Bank Location & Contents:	
Patient Trust Fund:	

Life Insurance:

Company Name	Policy #	Insured	Owner	Face Value	Surrender Value

Notes Receivable:	**Value**
Real Estate (Other Than Residence):	
☐ Tax-Appraised Value if any or ☐ 40X avg. Monthly Income	
Gas / Oil / Mineral Rights:	
County:	
Other (Describe):	
Attorney use only: Total Countable Resources:	

DEBTS:	Amount
Homestead Debt:	
Other Secured Debt:	
Unsecured Debt:	
Unsecured Debt:	
Attorney use only: Total debts: Net (after debts) countable resources:	

Your Income

Please indicate monthly income:

FIXED INCOME:	Amount
Social Security: Net Monthly Payment:	
Medicare Part B premium:	
Medicare Part D premium:	
SSI:	
VA:	
Railroad Retirement:	
Civil Service Annuities:	
Other Retirement:	
Pension:	
Annuities:	
Other Fixed Income:	
Attorney use only: Total fixed:	
VARIABLE INCOME:	
Gross Earned Income:	
Interest:	
Dividends:	
Stocks & Bonds:	
Rental/Notes:	
Oil & Gas:	
Farm Income:	
Other Income:	
Attorney use only Total variable: **Total income:**	

POSSIBLE DEDUCTIONS:	
Taxes withheld from income (monthly):	
Monthly health insurance premium:	

Other questions concerning your assets

Are you the beneficiary of a trust? ☐ Yes ☐ No
Transferred assets to a trust? ☐ Yes ☐ No
Anticipate an inheritance? ☐ Yes ☐ No
Received an inheritance? ☐ Yes ☐ No
(If Yes, be sure anything you still own is listed among your other assets above.)

Have you transferred cash or anything as a gift, for less than fair market value, in the last 5 years? ☐ Yes ☐ No
If Yes, give the following information as to each transfer:

Recipient:____
Asset description (if not cash): ____
Date: __________________________ Value of cash or other asset: $_______________
Received in return:
☐ Nothing (Gift) ☐ $_________Cash ☐ Other: ___________________ worth $__________
Was the transfer motivated, at least in part, by need for Medicaid eligibility? ☐ Yes ☐ No
If No, explain purpose(s) of transfer: ____

Recipient:____
Asset description (if not cash): ____
Date: __________________________ Value of cash or other asset: $_______________
Received in return:
☐ Nothing (Gift) ☐ $_________Cash ☐ Other: ___________________ worth $__________
Was the transfer motivated, at least in part, by need for Medicaid eligibility? ☐ Yes ☐ No
If No, explain purpose(s) of transfer: ____

Recipient:____
Asset description (if not cash): ____
Date: __________________________ Value of cash or other asset: $_______________
Received in return:
☐ Nothing (Gift) ☐ $_________Cash ☐ Other: ___________________ worth $__________
Was the transfer motivated, at least in part, by need for Medicaid eligibility? ☐ Yes ☐ No
If No, explain purpose(s) of transfer: ____

Questions concerning legal documents

Document	**Do you have this document?**	**Attorney use only: Document Adequate?**
Will	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Durable Power of Attorney (Financial)	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Power of Attorney for Health Care	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Directive to Physicians (Living Will)	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Court Appointed Guardianship of ☐ Estate ☐ Person	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Living (Revocable) Trust	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Documents funding Living Trust (deeds, etc.)	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain

Attorney use only – Notes concerning legal documents:

Attorney use only:

Goals of client:

☐ Acquire the best possible long term care, within his/her financial ability
☐ Keep in the family certain assets: ____
☐ Acquire effective wills and powers of attorney
☐ Protect a child or other person with a disability
☐ Other: ____
____
____
____
____

Checklist for Plan Preparation:

How to obtain documents to copy:

☐ Client provided all copies needed.
☐ We copied all at first conference.
☐ Returned original documents with plan after copying.
☐ Call ______________________ to pick up documents after copying.
☐ Have documents hand delivered to ______________________ after copying.

How to deliver plan:

☐ Call ________________________________ to pick up at our office.
☐ Have plan delivered by Fed Ex to ____
☐ Mail plan to the following: ____
☐ Email plan to the following: ____

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