Law Office of Michelle Peretz PLLC

CONFIDENTIAL
ESTATE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

DATE: _____

SECTION 1. NAME AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

_____

Relationship to Client: _____

Client's Full Name: _____
(first) (middle) (last)

Home Address: _____

_____

Client

Telephone Numbers: _____
(home)

_____
(cell)

Date of Birth: _____

Former/Maiden Names: _____

Social Security Number: _____

US Citizen?: [ ] Yes [ ] No

Military Service: [ ] Yes [ ] No

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SECTION 2. MARITAL INFORMATION

A. Date of Marriage: _____

B. Place of Marriage: _____
(city) (state or province) (country)

C. Client's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No _____
(still living?)

2. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No _____
(still living?)

SECTION 3. CHILDREN

List all children. Copy and attach additional pages, if needed. Total number of children: _____

1. _____ _____ _____
(name of child) (date of birth) (social security number)

_____ _____
(current address) (phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

2. _____ _____ _____

(name of child) (date of birth) (social security number)

(current address) (phone number)

[ ] Adopted (date of adoption) (court granting adoption)

[ ] Deceased (date of death) [ ] Yes [ ] No (child has surviving children?)

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

(Use additional pages, if needed)

3. (name of child) (date of birth) (social security number)

(current address) (phone number)

[ ] Adopted (date of adoption) (court granting adoption)

[ ] Deceased (date of death) [ ] Yes [ ] No (child has surviving children?)

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

(Use additional pages, if needed)

SECTION 4. DISPOSITIVE PLANNING

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations.

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

A. First-choice beneficiaries: [ ] Children [ ] Other

_____

_____

B. Second-choice beneficiaries: [ ] Children [ ] Other

_____

_____

C. Third-choice beneficiaries: [ ] Children [ ] Other

_____

_____

D. Any specific disposition of your residence?

_____

_____

E. Any specific gifts of special articles, such as art or jewelry?

_____

_____

F. Any specific disposition of household and personal effects?

_____

_____

G. Other information you think is important to your estate planning:

_____

SECTION 5. FIDUCIARIES

Please consider who you want to handle your affairs when you cannot.

A. EXECUTORS (Co-Executors Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

_____ _____
(current address) (phone number)

B. TRUSTEES (Co-Trustees Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

_____ _____
(current address) (phone number)

D. AGENTS UNDER POWER OF ATTORNEY (Co-Agents Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

_____ _____
(current address) (phone number)

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E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

SECTION 6. HEALTH-RELATED INFORMATION

Please describe Client's specific health-related problems.

_____

_____

_____

CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding? [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

B. OTHER ISSUES

Able to sign name?: [ ] Yes [ ] No

Able to speak?: [ ] Yes [ ] No

Able to recognize friends and family?: [ ] Yes [ ] No

Cognizant of property and possessions?: [ ] Yes [ ] No

Able to leave current residence?: [ ] Yes [ ] No

PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of your primary physician.

Physician's Name: _____

Specialty: _____

Address: _____

Business Phone: _____

SECTION 7. RESIDENCE -- OWNED

A. Owners: _____

B. How is title held? _____

PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL

C. Fair Market Value: $ _____

D. Mortgage Balance: $ _____

Is it a Reverse Annuity Mortgage (RAM)? [ ] Yes [ ] No

Basic Mortgage Terms: _____

E. Single Family Residence? [ ] Yes [ ] No

F. If the property is rental property, please provide the following:

1. Number of units: _____
2. Currently being rented? [ ] Yes [ ] No
3. Are tenants under lease? [ ] Yes [ ] No

G. If the property was purchased, please provide the following:

1. Date of Purchase: _____
2. Purchase Price: $ _____

H. If the property was inherited, please provide the following:

1. Month/Year Inherited: _____
2. Value when Inherited: $ _____

I. If improvements have been made to the property, please detail the value and nature of them:

_____

_____

_____

J. Have the owners used the capital gains tax exclusion? [ ] Yes [ ] No

K.If at least one occupant of the residence is a child of the individual in need of long-term care, has that child lived in the residence for at least 2 years? [ ] Yes [ ] No

1. If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? [ ] Yes [ ] No

2. If so, please describe the nature and duration of the care provided:

_____

_____

_____

L. Does the person needing care have any living children who are disabled? [ ] Yes [ ] No

If yes, please describe the nature of the disability:

_____

_____

M. Does the owner have a sibling who has lived in the house for at least 1 year? [ ] Yes [ ] No

If yes, does the sibling still reside in the home? [ ] Yes [ ] No

RESIDENCE -- RENTED

A. Monthly Rent: $ _____

B. Type of Rental: [ ] Single Family [ ] Apartment [ ] Residential Care
[ ] Life Care [ ] Senior Housing

C. Rental/Lease Agreement? [ ] Yes [ ] No

D. Is Rent Subsidized? [ ] Yes [ ] No

If so, by whom and amount? _____

SECTION 8. LONG-TERM CARE (LTC)

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

HOSPITAL

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

SECTION 9 FINANCIAL HEALTH

DEBT

Enter the outstanding balance of debt i.e., Credit Cards and Lines of Credit

Description/Type of Debt	Whose debt?	Creditor	Balance
Credit card (sample)	John and Jane's	US Bank	$ xx,xxx.xx
			$
			$
			$
			$
			$

INCOME

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment vehicle is the "owner" of the income.

A. FIXED MONTHLY INCOME

1. Social Security: $ _____

2. R.R. Retirement: $ _____

3. Pension: $ _____

4. _____: $ _____

B. NON-FIXED MONTHLY INCOME

1. Interest: $ _____

2. Dividends: $ _____

3. _____: $ _____

4. _____: $ _____

5. _____: $ _____

C. TOTALS (A thru B): $ _____

ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.) - Please provide copies of statements

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. (sample)	xxx-xxxx	Savings	$ xx,xxx.xx	Jointly w/ son
			$	
			$	
			$	
			$	
			$	

B. SECURITIES (Bonds, Marketable Securities, etc.) - Please provide copies of statements

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. (sample)	Common (or Preferred)	xx Shares	$ x,xxx.xx	$ x,xxx.xx	Sole owner
			$	$	
			$	$	
			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.) - Please provide copies of statements and designated beneficiary documentation.

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker (sample)	xxx-xxxx	Client	Spouse	Jan, 1970	$ xx,xxx.xx
					$
					$
					$

D. LIFE INSURANCE - If the person needing care has life insurance, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	Cash Surrender Value
Acme Insurance (sample)	123-45-6789	Whole Life	$ 1,000	$ 10,000
			$	$
			$	$
			$	$

E. REAL ESTATE - Please provide copies of deeds and most recent tax bills

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
123 Know Way (sample)	$ xxx,xxx.xx	$ xxx,xxx.xx	$ xx,xxx.xx	Joint tenant
	$	$	$	
	$	$	$	
	$	$	$	

F. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$	
Cars, RVs, Boats, etc.:	$	
Jewels, Furs, etc.:	$	
: (other: collectibles, etc.)	$	
:	$	

G. BUSINESS INTERESTS

If the person needing long-term care has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

H. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which the person needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

I. MISCELLANEOUS

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each.

SECTION 10. EXEMPT RESOURCES

FUNERAL AND OTHER ARRANGEMENTS

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

Burial plot: [ ] Yes [ ] No

Irrevocable burial fund contract: [ ] Yes [ ] No

PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

Responsible for Client:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

3. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

1. If you OWN YOUR HOME:
Total cost of mortgage, taxes, utilities, phone, etc.*: $ _____

*Is the Senior Citizen real property tax exemption being used? [ ] Yes [ ] No
Is the Veterans' real property tax exemption being used? [ ] Yes [ ] No

2. If you RENT YOUR HOME:
Total rent including maintenance fees, if any: $ _____

B. INSURANCE PREMIUMS (PER MONTH)

1. Health insurance: $ _____

2. Long-term care insurance: $ _____

3. _____: $ _____
(specify)

4. _____: $ _____
(specify)

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

1. Non-covered medications: $_____

2. _____: $_____
(specify)

3. _____: $_____
(specify)

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

1. Food: $_____

2. Entertainment and travel: $_____

3. Support for children: $_____

4. _____: $_____
(specify)

5. _____: $_____
(specify)

E. TOTALS (A thru D): $_____

HEALTH AND LTC INSURANCE

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
Acme Insurance (sample)	123-45-6789	Long-term care	$ 3,000	$ 300.00 per day
			$	$
			$	$
			$	$

SECTION 11. PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

Will:	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No
Pour-Over Will:	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No
Health Care Power of Attorney (or Proxy):	[ ] Yes [ ] No
Living Will:	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No

(specify)

TRANSFERS WITHIN THE LAST 60 MONTHS (5 YEARS)

Has the person needing care gratuitously transferred property to someone other than transferor's spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**: Please include transfers for financial assistance to anyone, other than in exchange for work.

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

TRANSFERS TO OR FROM TRUSTS

Has the person needing care (or his or her spouse) transferred property into a Trust—like an Irrevocable Life Insurance Trust (ILIT)—or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

SECTION 12. CLIENT'S GOALS

What are your goals?

_____

_____

_____