CONFIDENTIAL QUESTIONNAIRE
FOR SINGLE PERSON

I. Personal Information

Name As It Appears on Photo ID **Date of Birth** **Place of Birth**

_____

Mailing Address **Telephone**
Home (____) _____ Fax (____) _____

_____
Number Street City State Zip Email

Employer

_____ (____) _____
Name Address Job Title Telephone

Years of Residence in California: _____

If less than 10 years, note prior residences:

_____

Prior Marriages (state dates of prior marriages)

_____

Children, if any
Child #1

_____
Name Address & Phone Birth Date Age

_____
Marital Status Natural/Adopted Name of Spouse Any Children? (If so, list names)

Child #2

_____
Name Address & Phone Birth Date Age

_____
Marital Status Natural/Adopted Name of Spouse Any Children? (If so, list names)

Child #3

_____
Name Address & Phone Birth Date Age

_____
Marital Status Natural/Adopted Name of Spouse Any Children? (If so, list names)

Children (Deceased)

Child #1

Name Address Birth Date Age

Marital Status Natural/Adopted Name of Spouse Any Children? (If so, list names)

Child #2

Name Address Birth Date Age

Marital Status Natural/Adopted Name of Spouse Any Children? (If so, list names)

Parents

Father

Name Deceased? ☐ Yes ☐ No Address, if Living

Mother

Name Deceased? ☐ Yes ☐ No Address, if Living

Brothers and Sisters

Name Address & Phone

Name Address & Phone

Name Address & Phone

Are you a citizen of a foreign country? ____

If so, please state the foreign country: _____

Do you:	**Yes**	**No**
Expect to receive gifts from parents or others?	☐	☐
Expect to inherit something from parents or others?	☐	☐
Currently own stock in an S corporation (a small business corporation that elected to have income taxed to its shareholders)?	☐	☐

Currently receive benefits from a qualified retirement plan?
If so, please state the name of each plan and the year of retirement:

Plan Name	**Year of Retirement**
_____	_____
_____	_____
_____	_____

	Yes	**No**
Expect to receive benefits from a qualified retirement plan?	☐	☐
Have beneficial interest in trusts?	☐	☐
Have interest in buy-sell agreement?	☐	☐
Have an interest in generation-skipping trust?	☐	☐
Have powers of appointment?	☐	☐
Is any of your property former Community Property that you received from a previously deceased spouse?	☐	☐

If yes, please indicate names and date of death of previously deceased spouse(s):

_____

_____

Have you made gifts to your children or others in excess of $14,500 per person per year?	☐	☐

Name and Address of Accountant:

_____

Name Address

Name and addresses of others who know about your financial affairs:

_____

Name Address

II. ASSETS & LIABILITIES

REAL ESTATE	Please use these descriptions in the TYPE column for your Real Estate Assets: Primary Residence Land Rental Home Commercial Property Second Residence Vacation Home Rental Property	
Type	Description	Asset Value

BANK ACCOUNTS	Please use these descriptions in the TYPE column for your Bank Account Assets: Checking CD Savings Money Market	
Type	Description	Asset Value

INVESTMENT	Please use these descriptions in the TYPE column for your Investment Assets: Bonds Ltd. Partnership Preferred Stock Common Stock Mutual Fund Stock Brokerage	
Type	Description	Asset Value

RETIREMENT	Please use these descriptions in the TYPE column for your Retirement Assets: 401K IRA SEP/IRA 403b Qualified Plan Other	
Type	Description	Asset Value

BUSINESS	Please use these descriptions in the TYPE column for your Business Assets: General Partnership C Corporation Sole Proprietorship Ltd. Partnership (Bus.) S Corporation LLC	
Type	Description	Asset Value

LIFE INSURANCE & ANNUITIES	Please use these descriptions in the TYPE column for your Life Insurance & Annuities (continue to back of page if not enough space): Term Whole Life/Universal Life Other		
Type	Description	Measuring Life	Value
	Last 4 Digits of Account #_____ Company Name:_____ Address:_____ Beneficiary:_____		

NOTES & ACCOUNTS RECEIVABLE	Please describe all items over $100 due you:		
Date	Payor	Payee	Amount

PERSONAL PROPERTY	
Type	Asset Value
Home Furnishings	
Automobiles	
Jewelry	
Mobile Homes, Manufactured Homes, Recreational Vehicles	
Other (collections, etc.)	

LIABILITIES	Please use these descriptions in the TYPE column for your Liability Assets: Mortgage Other Loans Personal Loan	
Type	Description	Amount Owed

III. DISTRIBUTION & DESIGNATIONS

WHO WILL INHERIT YOUR ESTATE: (please include full name, address & phone write on the back of this page if you need more room)

_____

_____

_____

TRUSTEE(S):

Who will be your trustee(s)? (please include full name, address & phone)

_____

Who will be your back-up trustee(s)? (please include full name, address & phone)

_____

EXECUTOR(S):

Who will be your executor(s)? (please include full name, address & phone)

_____

Who will be your back-up executor(s)? (please include full name, address & phone)

_____

GUARDIAN(S) (applies only if you have children under the age of 18)**:**

Who will be the guardian(s) for your minor child or children? (please include full name, address & phone)

_____

Will they be the guardian of the person & the assets for the child or just the guardian of the child?

_____

DURABLE POWER OF ATTORNEY:

Who will be your Attorney In Fact to make financial decisions for you if you are unable or incapacitated? (please include full name, address & phone)

_____

Who will be your back-up Attorney In Fact? (please include full name, address & phone)

_____

ADVANCED HEALTH CARE DIRECTIVE:

Who will be your Agent to make health care decisions for you if you are unable or incapacitated? (please include full name, address & phone)

_____

Who will be your back-up Agent? (please include full name, address & phone)

_____

PLEASE FILL OUT ATTACHED HEALTH CARE QUESTIONNAIRE:

DOCUMENTS DESIRED BY ATTORNEY:

1. Copies of present Trusts and/or Wills, if any;

2. Copies of real property deeds, if any;

3. Copies of beneficiary designations for each of the following non-probate assets (including a copy of each written spousal consent to the beneficiary designation):

    a. Life insurance policies; Retirement Plans;

    b. Individual Retirement Accounts (IRAs, 401Ks, 403(b), etc.)

OPTIONS FOR ADVANCED HEALTH CARE DIRECTIVE

Agent for AHCD	Name: Address: Telephone:
Successor Agent AHCD	Name: Address: Telephone:
Autopsy (Check one)	❑ My agent may authorize an autopsy if she believes it necessary or helpful to an understanding of the circumstances surrounding my death. ❑ I recognize that an autopsy may sometimes be required by law, but when an autopsy is not required by law, I do NOT want my agent to authorize an autopsy.
Organ Donation (Check one)	❑ My agent may authorize donation. ❑ My agent may authorize donation of my organs with the following restrictions: _____ ❑ My agent may NOT donate my organs.
Funeral and Burial Instructions (Check one)	❑ My agent may authorize the disposition of my remains according to what the agent knows to be my preference.

	❑ My agent may authorize the disposition of my remains as noted on the back of this page. ❑ I have prepaid burial and funeral plans in place with the following entity: _____
End of Life Decisions (Check one)	❑ I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery and my death is likely to occur within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3)under any other circumstances in which the burdens of treatment outweigh the expected benefits. By an irreversible coma, I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.
	❑ I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma," I mean a coma from which the treating physician or physicians have reasonably concluded I will never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.
	❑ If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) "terminal condition" shall mean an incurable and irreversible condition caused by injury, disease or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and for which the application of life-sustaining procedures serves only to postpone the moment of my death, and (2) "life-sustaining procedures" shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which will serve only to artificially prolong the moment of my death. The term "life-sustaining procedures" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.
	❑ I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted healthcare standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.