STEPHANIE L. SCHNEIDER, P.A.
ESTATE, HEALTH CARE AND MEDICAID PLANNING QUESTIONNAIRE

INSTRUCTIONS:

(A) PLEASE COMPLETE THE QUESTIONNAIRE COMPLETELY TO THE BEST OF YOUR ABILITY. YOU MAY CALL OUR OFFICE FOR ASSISTANCE.

(B)YOUR ACCURACY AND COMPLETENESS IN RESPONDING WILL HELP US TO BEST ADVISE AND REPRESENT YOU. PLEASE COMPLETE ALL PARTS OF THE QUESTIONNAIRE OR WE WILL BE UNABLE TO MEET WITH YOU.

I. GENERAL INFORMATION

1. Were you referred to our office and if so, by whom? _____.
2. If not, what made you choose our office? _____.
3. What is the purpose of your visit to our office? _____.
4. Do you or your partner have any other legal issues which our office should be aware of? ___. If yes, please explain: _____.

II. BACKGROUND AND FAMILY INFORMATION

1. Partner 1 Name:_____
   D.O.B.:_____ SS#_____
   Phone Number(s):(H) _____ (C)_____ (O)_____
   E-mail_____
   Current Address:_____
   If deceased, date, county and state of death: _____.

2. Partner 2 Name: _____
   D.O.B.:_____ SS#_____
   Phone Number(s):(H) _____ (C)_____ (O)_____
   E-mail_____
   Current Address:_____
   If deceased, date, county and state of death: _____.

3. Relationship Began:_____

4. Children (please indicate whether any child is from a prior marriage). For minors, include their age:

Included Deceased Children

	PARTNER 1	**PARTNER 2**
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____
Adopted/Half-blood	_____	_____
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____
Adopted/Half-blood	_____	_____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____
Adopted/Half-blood _____ _____

5. Grandchildren:

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____
Adopted/Half-blood _____ _____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____
Adopted/Half-blood _____ _____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____
Adopted/Half-blood _____ _____

6. If no surviving children, list names of living siblings for each partner.

PARTNER 1 **PARTNER 2**

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____

7. Names of living parents:

	PARTNER 1	**PARTNER 2**
Name\Age		
Relationship		
Address		
Phone #		
Name\Age		
Relationship		
Address		
Phone #		

III. HEALTH INSURANCE: PLEASE PROVIDE THE NAME AND ADDRESS OF THE COMPANY FOR THE FOLLOWING:

	PARTNER 1	**PARTNER 2**
Medicare/Private Insurance		
Company:		
Address:		
Medicare Supplement		
Company:		
Address:		
Long Term Care Insurance		
Company:		
Address:		
Other, Cancer, Accidental, Disability		
Company:		
Address:		

IV. PERSONAL INFORMATION

1. Have you or your partner used your over-age 55 exemption from capital gains taxes on the sale of a residence? _____

2. Have arrangements been made for the disposition of your body at death? _____ Are they paid for? _____ Please describe the arrangements and who they are with:_____ _____.

3. Are you or your partner a veteran? ____ If yes, did you serve in wartime? ___ Do you currently receive any benefits? __ If yes, please explain:_____.

4. Are you or your partner at risk because of a medical condition or family history of becoming seriously ill or disabled or, are you presently experiencing an illness? __ If yes please explain: _____ _____.

5. Does anyone to whom you may be leaving part of your estate require help or protection in managing money or other property? __ If yes, please explain._____.

V. ASSETS

1. Real Estate located in Florida:

Address: _____
FMV: _____
(Indicate whether based on sale price, appraisal or tax bill)
Mortgage: _____
(Indicate name of mortgagee and balance of mortgage)
Title held by: _____
(Indicate persons and whether title is held as tenants in common, joint tenancy with rights of survivorship, tenancy by entirety)
Homestead Exemption Filed:_____

2. Real estate located outside Florida:
Address: _____
FMV: _____
(Indicate whether based on sale price, appraisal or tax bill)
Mortgage: _____
(Indicate name of mortgagee and balance of mortgage)
Title held by: _____
(Indicate persons and whether title is held as tenants in common, joint tenancy with rights of survivorship, tenancy by entirety)

3. Automobiles, Mobile Homes, Recreational Vehicles, Boats:

Type	Year	FMV	Liens	Owner

4. Stocks, securities, bonds, and investments:

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

5. Retirement and pension plans (include IRAs and 401Ks):

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
Taking minimum distribution Y-N:_____Amount $_____Frequency_____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
Taking minimum distribution Y-N _____ Amount $ _____ Frequency _____
Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
Taking minimum distribution Y-N_____Amount$_____ Frequency _____

6. Bank Accounts:

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #: _____
How is it titled: _____
When does it come due and interest rate: _____

7. Life insurance:

	PARTNER 1	PARTNER 2
Name of Owner	_____	_____
Name of Insured	_____	_____
Name of Insurer	_____	_____
Policy #:	_____	_____
Face Value:	_____	
Cash Surrender Value:	_____	
Term or whole life:	_____	_____
Beneficiary (ies):	_____	

Name of Owner	_____	_____
Name of Insured	_____	_____
Name of Insurer	_____	_____
Policy #:	_____	_____
Face Value:	_____	
Cash Surrender Value:	_____	
Term or whole life:	_____	_____
Beneficiary (ies):	_____	

8. Annuities:

Asset: _____ Value: _____ Account #: _____
Name & Address of Co. _____
How is it titled: _____ When does it come due and interest rate: _____
Are there survivorship benefits and who is the beneficiary: _____

Asset: _____ Value: _____ Account #: _____
Name & Address of Co. _____
How is it titled: _____ When does it come due and interest rate: _____
Are there survivorship benefits and who is the beneficiary: _____

9. Other Assets (Debts owed by others to you including description of debt, name of debtor, current unpaid balance, identify document which evidences debt):

Business interest in corporation or partnership (include name, address, percent of stock owned, book value and fair market value of stock, whether you have a Buy/Sell Agreement, Stock Option Agreement, Deferred Compensation Agreement, or other employee benefit plans) : _____
_____
_____
_____

Mortgages: _____

Promissory notes: _____

Inheritance (Are you receiving or do you expect to receive an inheritance in the near future), Powers of Appointment: _____

TOTAL OF ALL PROPERTY: $ _____

VI. GROSS MONTHLY INCOME: THIS MUST INCLUDE INCOME FROM ALL SOURCES, EVEN IF REINVESTED, AS WELL AS ANY DEDUCTIONS FROM SOCIAL SECURITY OR PENSIONS. IF YOU RECEIVE A PENSION, BRING THE BOTTOM OF YOUR MOST RECENT CHECK.

	PARTNER 1	**PARTNER 2**	**JOINT**
Social Security	$_____	$_____	
Employment	$_____	$_____	
Pensions	$_____	$_____	
	From: _____	From: _____	
	$_____	$_____	
	From: _____	From: _____	
IRA's	$_____	$_____	
Annuities	$_____	$_____	
Interest on Bank Accounts, Savings Accounts, C.D.'s:			
	$_____	$_____	$_____
Dividends on Stocks and Bonds:			
	$_____	$_____	$_____
Other (i.e. rent)	$_____	$_____	$_____
TOTALS:			
	$_____	$_____	$_____

Which sources of income have a benefit for a surviving partner? _____
_____

VII. MONTHLY ESTIMATED BUDGET

Rent/Mortgage Payment/Facility	$_____
Utilities:	$_____
Car Payment/Maintenance:	$_____

Clothing:	$_____
Food/Personal Household:	$_____
Insurance:	$_____
Medical Expenses (incl. Prescriptions)	$_____
Taxes:	$_____
Vacation/Entertainment:	$_____
Emergency Fund:	$_____
Other:	$_____
TOTAL MONTHLY EXPENSES:	$_____

VIII. **MONTHLY LIABILITIES**

Mortgages:	$_____
Notes to banks:	$_____
Notes to others:	$_____
Unpaid medical:	$_____
Charge card bills:	$_____
Other:	$_____
TOTAL MONTHLY LIABILITIES:	$_____

IX. TRANSFERS OF ASSETS. THIS INFORMATION MUST BE COMPLETED IN FULL. IF YOU DO NOT COMPLETE THIS PORTION WE WILL NOT BE ABLE TO CONDUCT THE INTERVIEW.

1. Have you or your partner made any gifts or transfers, of any amount, to any individuals or charities including the other partner within the last sixty (60) months? Yes _____ No _____ If yes, complete the following:

PARTNER 1	**PARTNER 2**
Name of recipient:_____	Name of recipient:_____
Date of Gift:_____	Date of Gift:_____
Item: _____	Item: _____
Value: _____	Value: _____
Name of recipient:_____	Name of recipient:_____
Date of Gift:_____	Date of Gift:_____
Item: _____	Item: _____
Value: _____	Value: _____
Name of recipient:_____	Name of recipient:_____
Date of Gift:_____	Date of Gift:_____
Item: _____	Item: _____
Value: _____	Value: _____

Name of recipient:_____ Name of recipient:_____
Date of Gift:_____ Date of Gift:_____
Item: _____ Item: _____
Value: _____ Value: _____

X. LEGAL DOCUMENTS

A. Last Will & Testament of Partner 1:

1. Name of Personal Representative:_____
Address of Personal Representative:_____
Name of Successor Personal Representative:_____
Address of Successor Personal Representative:_____

2. Name(s) of beneficiary(ies), their address and their respective share of the estate (indicate beneficiaries who are minors and at what age they are to receive part or all of their share):

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Charity Name _____
Address _____ Phone # _____

Charity Name _____
Address _____Phone # _____

3. Is there a domestic partner agreement in place?_____

4. If you have minor children, do you wish to name a pre-need guardian? Yes ___. I wish to name:
_____. No __

5. Do you wish to name a preneed guardian for yourself? Yes __. I wish to name: _____ _____. No ___

B. Last Will & Testament of Partner 2:

1. Name of Personal Representative:_____
Address of Personal Representative:_____
Name of Successor Personal Representative:_____
Address of Successor Personal Representative:_____

2. Name(s) of beneficiary(ies), their address and their respective share of the estate (indicate beneficiaries who are minors and at what age they are to receive part or all of their share):

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____ _____.

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____ _____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____ _____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____ _____.

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____ _____.

Charity Name _____
Address _____ Phone # _____

Charity Name _____
Address _____Phone # _____

3. Is there a domestic partner agreement in place?_____

4. If you have minor children, do you wish to name a pre-need guardian? Yes ___. I wish to name: _____. No __

5. Do you wish to name a preneed guardian for yourself? Yes __. I wish to name: _____ _____. No ___

C. Durable Power of Attorney for Partner 1: If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship?

1. Name: _____
Address: _____
Relationship to you: _____

2. Name: _____
Address: _____
Relationship to you: _____

3. Indicate with a check mark (✓) whether you wish to give your agent the authority to handle the following matters:

Yes	No	Legal Authority
		Create an inter vivos trust (i.e., revocable living trust)
		Make a gift (subject to restrictions)
		Create or change a beneficiary designation on life insurance
		Create or change a beneficiary designation on other assets
		Disclaim property to which you may be entitled

Yes	No	Legal Authority
		Amend, modify, revoke or terminate a trust (trust must give agent this authority also)
		Create or change rights of survivorship
		Waive your right to be a beneficiary of a joint and survivor annuity, including under a retirement plan
		Disclaim powers of appointment

4. An agent is entitled to reimbursement of expenses reasonably incurred on your behalf. A qualified agent (spouse, heir, financial institution with trust powers, attorney, Certified Public Accountant) is entitled to reasonable compensation unless you decide otherwise. Do you want your agent to be compensated? _____ Yes _____ No

5. The Durable Power of Attorney is effective when signed. This means if your agent gets the original or a photocopy, he/she can begin making financial decisions for you immediately even if you are healthy and not incapacitated.

Do you want to keep the original Durable Power of Attorney? _____ Yes _____ No
Do you want our law firm to hold the original document as your escrow agent? _____ Yes _____ No

D. Durable Power of Attorney for Partner 2: If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship?

1. Name: _____
Address: _____
Relationship to you: _____

2. Name: _____

Address: _____
Relationship to you: _____

3. Indicate with a check mark (✓) whether you wish to give your agent the authority to handle the following matters:

Yes	No	Legal Authority
		Create an inter vivos trust (i.e., revocable living trust)
		Make a gift (subject to restrictions)
		Create or change a beneficiary designation on life insurance
		Create or change a beneficiary designation on other assets
		Disclaim property to which you may be entitled

Yes	No	Legal Authority
		Amend, modify, revoke or terminate a trust (trust must give agent this authority also)
		Create or change rights of survivorship
		Waive your right to be a beneficiary of a joint and survivor annuity, including under a retirement plan
		Disclaim powers of appointment

4. An agent is entitled to reimbursement of expenses reasonably incurred on your behalf. A qualified agent (spouse, heir, financial institution with trust powers, attorney, Certified Public Accountant) is entitled to reasonable compensation unless you decide otherwise. Do you want your agent to be compensated? _____ Yes _____ No

5. The Durable Power of Attorney is effective when signed. This means if your agent gets the original or a photocopy, he/she can begin making financial decisions for you immediately even if you are healthy and not incapacitated.

Do you want to keep the original Durable Power of Attorney? _____ Yes _____ No
Do you want our law firm to hold the original document as your escrow agent? _____ Yes _____ No

E. Designation of Health Care Surrogate for Partner 1: If you become unconscious or unable to communicate, do you want someone to make your medical decisions and thereby avoid a guardianship?

1. Name of Primary Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

2. Name of Alternate Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

3. Name(s) of those persons, other than your surrogate, who you wish to send a copy of the executed document (i.e. your treating physician; family member):_____

F. Designation of Health Care Surrogate for Partner 2: If you become unconscious or unable to communicate, do you want someone to make your medical decisions and thereby avoid a guardianship?

1. Name of Primary Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

2. Name of Alternate Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

3. Name(s) of those persons, other than your surrogate, who you wish to send a copy of the executed document (i.e. your treating physician; family member):_____

G. Living Will for Partner 1: If you are diagnosed with a terminal condition and your attending physician has determined that there can be no recovery from such condition and death is imminent do you want your life prolonged? Yes _____ No _____

1. In the event you can no longer chew food and swallow liquids orally, do you wish to receive food and water through artificial means such as a feeding tube surgically implanted in the stomach, an intravenous tube in the arm or, a nasogastric tube? Yes ____ No ____

2. Do you wish to receive medication for pain even if the amount of pain medication dulls your senses? Yes ____ No _____

3. Would you like to be cared for by Hospice. Hospice provides palliative care which includes feeding, dressing and bathing the person and administering pain medication. Hospice will not perform life sustaining measures such as CPR or restore breathing. Yes ____ No _____

4. If you also have a secondary illness (i.e. pneumonia, virus, cold) do you want the secondary illness treated (treating the secondary illness will not heal or correct the terminal illness)?
Yes ____ No _____

5. If you stopped breathing or your heart stopped beating would you want to be resuscitated?
Yes ___ No ____

6. Would you like to aid medical development in the fields of tissue and organ preservation, transplantation of tissues and tissue culture, reconstructive medicine and surgery and the development of medical research? If your body or organs are medically acceptable, upon your death do you wish to make an anatomical gift? Yes ___ No ____

If you answer "Yes" please complete the following:

a) I wish to give _____ any needed organs or parts _____only the following organs or parts:

_____
Specify the organ(s) or part(s))

_____

for the purpose of transplantation, therapy, medical research, or education;

b) _____ my body for anatomical study if needed. Limitations or special wishes, if any, are as follows: _____

H. Living Will for Partner 2: If you are diagnosed with a terminal condition and your attending physician has determined that there can be no recovery from such condition and death is imminent do you want your life prolonged? Yes ____ No _____

1. In the event you can no longer chew food and swallow liquids orally, do you wish to receive food and water through artificial means such as a feeding tube surgically implanted in the stomach, an intravenous tube in the arm or, a nasogastric tube? Yes ____ No ____

2. Do you wish to receive medication for pain even if the amount of pain medication dulls your senses? Yes ____ No _____

3. Would you like to be cared for by Hospice. Hospice provides palliative care which includes feeding, dressing and bathing the person and administering pain medication. Hospice will not perform life sustaining measures such as CPR or restore breathing. Yes ____ No _____

4. If you also have a secondary illness (i.e. pneumonia, virus, cold) do you want the secondary illness treated (treating the secondary illness will not heal or correct the terminal illness)? Yes ____ No _____

5. If you stopped breathing or your heart stopped beating would you want to be resuscitated? Yes ____ No ____

6. Would you like to aid medical development in the fields of tissue and organ preservation, transplantation of tissues and tissue culture, reconstructive medicine and surgery and the development of medical research? If your body or organs are medically acceptable, upon your death do you wish to make an anatomical gift? Yes ____ No ____

If you answer "Yes" please complete the following:

a) I wish to give _____ any needed organs or parts _____only the following organs or parts:

_____

Specify the organ(s) or part(s))

_____

for the purpose of transplantation, therapy, medical research, or education;

b) _____ my body for anatomical study if needed. Limitations or special wishes, if any, are as follows:

_____

_____

I. Living Trust for Partner 1(a/k/a Revocable Trust)

1. Do you want to eliminate the need to probate your estate and have your assets distributed within a short time after your passing? Yes _____ No ____

2. Name & address of Trustee or Co-Trustees:_____
_____

3. Name & address of first successor trustee: _____
_____

4. Name & address of second successor trustee: _____
_____

5. Disposition upon death of surviving partner: _____
_____
_____.

6. In the event a beneficiary predeceases or fails to survive you, who should receive that person's share:_____.

J. Living Trust for Partner 2(a/k/a Revocable Trust)

1. Do you want to eliminate the need to probate your estate and have your assets distributed within a short time after your passing? Yes _____ No ___

2. Name & address of Trustee or Co-Trustees:_____
_____

3. Name & address of first successor trustee: _____
_____

4. Name & address of second successor trustee: _____
_____

5. Disposition upon death of surviving partner: _____
_____
_____.

6. In the event a beneficiary predeceases or fails to survive you, who should receive that person's share:_____.

K. ***DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS (for Partner 1)***

a. Would you like to designate in writing a trusted individual to make or, enforce arrangements for the disposition of your body at the time of your death? Yes ____ No _____
This individual would have authority to set the time and place of a service, communicate with a medical examiner, receive your cremains as well as take steps to enforce any anatomical gift you desire.

b. If yes, identify the primary authorized representative:
Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

c. If yes, identify the successor authorized representative:

Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

d. What is your preference for final arrangements? Burial _____ Cremation _____

e. Detail any restrictions you want to place on the representative's authority: _____
_____
_____

L. ***DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS (for Partner 2)***

a. Would you like to designate in writing a trusted individual to make or, enforce arrangements for the disposition of your body at the time of your death? Yes ____ No _____
This individual would have authority to set the time and place of a service, communicate with a medical examiner, receive your cremains as well as take steps to enforce any anatomical gift you desire.

b. If yes, identify the primary authorized representative:
Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

c. If yes, identify the successor authorized representative:
Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

d. What is your preference for final arrangements? Burial _____ Cremation _____

e. Detail any restrictions you want to place on the representative's authority: _____
_____
_____

M. Do you have any professional advisors who you wish us to work with? Please provide us with their names, addresses and telephone number. If you are not currently working with any of the following professionals, would you like our office to provide you with a recommendation? ___ Yes ___ No

Accountant:_____

Financial Planner:_____

Insurance Advisor: _____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____

Print Name: _____

Date: _____

_____

Print Name: _____

Date: _____

F:\CLIENTS\Office-Forms\Questionnaire-Est&Medicaid-DomesticPartners.wpd