

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

**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 spouse have any other legal issues which our office should be aware of? \_\_\_\_\_. If yes, please explain: \_\_\_\_\_.

**II. BACKGROUND AND FAMILY INFORMATION**

1. Husband's Name: \_\_\_\_\_  
Husband's D.O.B.: \_\_\_\_\_ SS# \_\_\_\_\_  
Phone Number(s):(H) \_\_\_\_\_ (C) \_\_\_\_\_ (O) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Current Address: \_\_\_\_\_  
If deceased, date, county and state of death: \_\_\_\_\_.
2. Wife's Name: \_\_\_\_\_  
Wife's D.O.B.: \_\_\_\_\_ SS# \_\_\_\_\_  
Phone Number(s):(H) \_\_\_\_\_ (C) \_\_\_\_\_ (O) \_\_\_\_\_  
E-mail \_\_\_\_\_  
Current Address: \_\_\_\_\_  
If deceased, date, county and state of death: \_\_\_\_\_.
3. Date of Marriage: \_\_\_\_\_ Is this a 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> Marriage: \_\_\_\_\_
4. Children (please indicate whether any child is from a prior marriage). For minors, include their age:

**Included Deceased Children**

	<b><u>HUSBAND</u></b>	<b><u>WIFE</u></b>
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____
Adopted/Half-blood	_____	_____
Name\Age	_____	_____
Relationship	_____	_____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

Address	_____	_____
Phone #	_____	_____
Adopted/Half-blood	_____	_____
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 spouse.

	<u>HUSBAND</u>	<u>WIFE</u>
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____
Name\Age	_____	_____
Relationship	_____	_____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

Address \_\_\_\_\_  
Phone # \_\_\_\_\_

7. Names of living parents:

**HUSBAND**

**WIFE**

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:**

**HUSBAND**

**WIFE**

Medicare/Private Insurance

Company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medicare Supplement

Company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Long Term Care Insurance

Company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other, Cancer, Accidental

Company: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**IV. PERSONAL INFORMATION**

1. Have you and your spouse 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 spouse a veteran? \_\_\_\_\_ If yes, did you serve in wartime? \_\_\_ Do you currently receive any benefits? \_\_\_ If yes, please explain: \_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

4. Are you or your spouse 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 because he/she has a disability or is not physically responsible?  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:

<u>Type</u>	<u>Year</u>	<u>FMV</u>	<u>Liens</u>	<u>Owner</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 #: \_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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: \_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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:

HUSBAND

WIFE

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

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\_\_\_\_\_

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

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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: \_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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.

	<b>HUSBAND</b>	<b>WIFE</b>	<b>JOINT</b>
<u>Social Security</u>	\$ _____	\$ _____	
<u>Employment</u>	\$ _____	\$ _____	
<u>Pensions</u>	\$ _____	\$ _____	
From: _____		From: _____	
	\$ _____	\$ _____	
From: _____		From: _____	
<u>IRA's</u>	\$ _____	\$ _____	
<u>Annuities</u>	\$ _____	\$ _____	
<u>Interest on Bank Accounts, Savings Accounts, C.D.'s:</u>			
	\$ _____	\$ _____	\$ _____

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

Dividends on Stocks and Bonds:

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Other (i.e. rent) \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**TOTALS:**

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Which sources of income have a benefit for a surviving spouse? \_\_\_\_\_  
\_\_\_\_\_

**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.**



ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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

**HUSBAND**

**WIFE**

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

**X. LEGAL DOCUMENTS**

**A. Last Will & Testament of Husband:**

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: \_\_\_\_\_  
\_\_\_\_\_.

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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 pre or post-nuptial agreement? \_\_\_\_\_

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 Wife:

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: \_\_\_\_\_  
\_\_\_\_\_.

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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 pre or post-nuptial agreement? \_\_\_\_\_

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 Husband: 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:

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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 Wife: 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:

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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 Husband: 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 Wife: 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: \_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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 Husband: 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: \_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

H. Living Will for Wife: 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 Husband (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: \_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

3. Name & address of first successor trustee: \_\_\_\_\_  
\_\_\_\_\_

4. Name & address of second successor trustee: \_\_\_\_\_  
\_\_\_\_\_

5. Disposition upon death of second spouse: \_\_\_\_\_  
\_\_\_\_\_

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

7. Credit shelter trust: \_\_\_\_\_  
\_\_\_\_\_

8. Marital deduction trust: \_\_\_\_\_  
\_\_\_\_\_

J. Living Trust for Wife (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 second spouse: \_\_\_\_\_  
\_\_\_\_\_

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

7. Credit shelter trust: \_\_\_\_\_  
\_\_\_\_\_

8. Marital deduction trust: \_\_\_\_\_  
\_\_\_\_\_

K. **DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS** (Husband)



ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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** (Wife)

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ESTATE, HEALTH CARE & MEDICAID PLANNING QUESTIONNAIRE-MARRIED

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: \_\_\_\_\_

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