LAW OFFICE OF STEPHANIE L. SCHNEIDER, P.A.
PLANNING FOR VETERAN BENEFITS QUESTIONNAIRE-SINGLE ____

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. Do you or your spouse have any other legal issues which our office should be aware of? __. If yes, please explain: ____.

II. BACKGROUND INFORMATION

1. Your Name:____
   D.O.B.:___________ SS#__________________
   Phone Number(s):(H) __________________ (O)________________; Email: ________________
   Current Address:____

2. Date widowed: ________ divorced:_____ separated: ________ Never married:________

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

		Included Deceased Children
Name/Age	__________________________	____
Relationship	__________________________	____
Address	__________________________	____
Phone #	__________________________	____
Adopted/Half-blood	______________________	____
Name/Age	__________________________	____
Relationship	__________________________	____
Address	__________________________	____
Phone #	__________________________	____
Adopted/Half-blood	______________________	____
Name/Age	__________________________	____
Relationship	__________________________	____
Address	__________________________	____
Phone #	__________________________	____
Adopted/Half-blood	________________________	_________________________________

4. Grandchildren:

Name/Age	__________________________	____
Relationship	__________________________	____
Address	__________________________	____
Phone #	__________________________	____
Adopted/Half-blood	______________________	____
Name/Age	__________________________	____
Relationship	__________________________	____
Address	__________________________	____
Phone #	__________________________	____
Adopted/Half-blood	______________________	____

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS-SINGLE

Name/Age ____________ ____________
Relationship ____________ ____________
Address ____________ ____________
Phone # ____________ ____________
Adopted/Half-blood ____________ ____________

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

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 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. 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. MILITARY SERVICE: Indicate the time frame you served by 'yes' or 'no'.

	YOU	**DECEASED SPOUSE**
Mexican Border (5/9/16 - 4/5/17)	____________	
World War I (4/16/17 - 11/11/18)	____________	
WWI Russia (4/6/17-4/1/20 - 7/1/21)	____________	
World War II (12/7/41- 12/31/46)	____________	
Korean Conflict (6/27/50 - 1/31/55)	____________	
Vietnam Era (8/5/64- 5/7/75	____________	
Vietnam (2/28/61 - 8/5/64)	____________	
Persian Gulf War (8/2/90 - ?)	____________	

1. Did you receive an Honorable Discharge? Yes _______ No _______

2. Did you have 90+ days of active duty? Yes ______ No _______

3. Was at least 1 day during wartime? Yes _______ No _______

4. Do you require care or assistance on a regular basis to protect you from dangers in your daily environment? Yes _______ No _______

5. Do you have a current medical condition that may have been caused by an event during your service? Yes _______ No _______

6. Did you have a medical condition prior to entering the service that may have been aggravated since your service? Yes _______ No _______

Do you now receive service connected compensation for this aggravated condition?

Yes _______ $______ No _______

7. Were your service records documented with a medical condition or, symptom caused during your service? Yes _______ No _______

8. Do you have a deceased child who was a veteran?
Yes _______ No _______

9. Were you dependent upon your deceased child for financial support?
Yes _______ No _______

VI. ASSETS

1. Your home 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. Other real estate (other than your home) located in or 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:

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: $ ___________________

VII. 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.

Social Security $___________

VA Disability $_________________________$______________

VA DIC $_________________________$______________

Employment $___________

Pensions $___________
From: ________________

$___________
From: ________________

IRA's $___________

Annuities $___________

Interest on Bank Accounts, Savings Accounts, C.D.'s:
$___________

Dividends on Stocks and Bonds:

$___________

Other (i.e. rent) $__________

TOTAL:
$___________

VIII. 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: $_________

IX. MONTHLY LIABILITIES

Mortgages: $_________
Notes to banks: $_________
Notes to others: $_________
Unpaid medical: $_________
Charge card bills: $_________
Other: $_________

TOTAL MONTHLY LIABILITIES: $_________

X. UNREIMBURSED MEDICAL EXPENSES. Identify those expenses you have already paid that are not covered by insurance. Focus on expenses that are recurring (indicate those that are infrequent). Identify the amount paid and to whom.

1. Health insurance premiums (Medicare; long term care):____________________

2. Over the counter medicines taken at doctor's direction: ____________________

3. Mechanical & electronic devices:____________________

4. Adult day care center (i.e. Alzheimer's program):____________________

5. Nursing home or other facility:____________________

6. In home attendant (aide) that provides some medical or nursing services: ____________________

7. Assisted living facility: ____________________

8. Prescriptions: ____________________

XI. TRANSFERS OF ASSETS. THIS INFORMATION MUST BE COMPLETED IN FULL.
Have you 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:

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: ____________________

XII. What is the name, address and phone number of your primary care physician? ____________________

XIII. 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: ______________________________

LEGAL DOCUMENTS

A. Last Will & Testament:

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

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

B. Durable Power of Attorney: 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

C. Designation of Health Care Surrogate: 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):________________________________

D. Living Will: 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: ____

____

E. Living Trust (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 your death: ____
____
____.

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

F. ***DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS***

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: ______________________
____
____

G. 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: ____________________________________

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