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Accredited by The American Bar Association
● *Also Admitted in New York*
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PROVIDING:
ELDER LAW SERVICES
ESTATE PLANNING AND TRUST ADMINISTRATION
MEDICAID AND PUBLIC BENEFITS PLANNING
SPECIAL NEEDS PLANNING
GUARDIANSHIP SERVICES
WILL CONTESTS AND PROBATE LITIGATION
NURSING HOME LAW AND LITIGATION
VA BENEFITS PLANNING
FAMILY LAW SERVICES
COLLABORATIVE LAW
MEDIATION SERVICES
SOCIAL SECURITY DISABILITY APPEALS

CONFIDENTIAL CLIENT QUESTIONNAIRE for ESTATE PLANNING

This questionnaire is intended to elicit the basic information we need to help you with estate planning. The more complete and accurate your responses, the better we will be able to help you. Please bring the completed form with you to our first meeting, along with the following documents, if available: estate documents (wills, trusts, etc.), financial statements, last year's tax returns, insurance policies, deeds, divorce decrees, prenuptial agreements, and guardianship documents. **All information will be held in the strictest confidence.**

Today's Date _____

I. GENERAL INFORMATION.

Full Name: _____

Address: _____

Tel. Home: _____ Tel. Bus: _____

Fax: _____ E-mail: _____

US Citizen? Yes: _____ No: _____ Birth Date: _____ Age: _____

Social Security Number: _____

II. FAMILY, FRIENDS, and OTHERS.

Prior Marriages: _____

Children from Prior Marriages: _____
Continuing Support Obligations: _____

Who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?: _____

CHILDREN

Name	Address	Age	Sex	Telephone Number	Spouse's Name

Please explain any special medical, educational, or other extraordinary personal or financial needs of any child:_____

_____

GRANDCHILDREN

Name	Address/Parent Name	Age	Sex	Marital Status	Spouse's Name

Please explain any special medical, educational, or other extraordinary personal or financial needs of any grandchild: _____

_____

_____

Are all your children / grandchildren in good health? Yes ☐ No ☐
Are any of your children / grandchildren blind? Yes ☐ No ☐
Are any of your children / grandchildren disabled? Yes ☐ No ☐
Do any of your children / grandchildren receive SSI, Medicaid or other government benefits? Yes ☐ No ☐

Do you or any of your family members have any problems with:

AIDS? Yes ☐ No ☐ Drug Addiction? Yes ☐ No ☐

Alcoholism? Yes ☐ No ☐ Spendthrift? Yes ☐ No ☐

Marital Difficulty? Yes ☐ No ☐

Do you trust your children's spouses? Yes ☐ No ☐

Are you concerned about potential litigation against you? Yes ☐ No ☐

PARENTS (YOURS AND YOUR SPOUSE'S)

Name	Address	Age	Sex	Marital Status	Spouse's Name

Please explain any special medical or financial needs of any parent:

Is anyone (other than your spouse) dependent upon you for support? If so, identify the person, and provide the reason for, and extent of, support:

III. GENERAL FINANCIAL INFORMATION. Basic financial information is critical to estate planning. Attach additional sheets as necessary.

Your Estimated Net Worth: $_____.

REAL ESTATE

TYPE AND LOCATION	COST	CURRENT VALUE	OWNERSHIP*

*JT=Joint Tenants; TC= Tenants-in-Common.

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BANK ACCOUNTS

Bank Name and Address	Type of Acct*	Account Number	Owner	Amount on Deposit

*Checking Account (CA), Savings Account (SA), Certificates of Deposit (C), Money Market Accts (MMA)

STOCKS, BONDS, TREASURY NOTES

NAME	ESTIMATED COST	ESTATE VALUE	OWNERSHIP*

*JT=Joint Tenants; TC= Tenants-in-Common.

PARTNERSHIPS AND OTHER INVESTMENTS

NAME OF INVESTMENT	TYPE OF INVESTMENT	CURRENT VALUE	OWNERSHIP*

*JT=Joint Tenants; TC= Tenants-in-Common.

RETIREMENT ACCOUNTS: IRAs, KEOUGHS, 401(K), ETC.

TYPE OF ACCOUNT	TAX BASIS	CURRENT VALUE	OWNERSHIP*

*JT=Joint Tenants; TC= Tenants-in-Common.

LIFE INSURANCE and ANNUITY CONTRACTS

Company Name and Address	Owner	Cash Surrender Value / Death Benefit	Policy Number	Primary / Alternate Beneficiaries

BUSINESS INTERESTS

Company	Owner	Type*	Percentage Ownership	Value	Buy/Sell Agreement

*Corporation (C), Sole Proprietorship (SP), Partnership (P), Limited Liability Co. (LLC)

VALUABLE PERSONAL PROPERTY: AUTOMOBILES, JEWELRY, COLLECTIONS AND THE LIKE

ASSET	OWNER	VALUE

Do you expect to inherit significant property? Yes ☐ No ☐ If yes, please explain: _____

Are you the beneficiary of any trust? Yes ☐ No ☐ If yes, provide the terms and conditions of the trust, amount of principal, etc. _____

_____

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DIGITAL ASSETS

Do you have any digital assets including the following:

☐ Security System--Primary Residence: Code: .....
☐ Security System--Vacation Residence: Code: .....
☐ Desktop computer: Username: ..... Password .....
☐ Laptop computer: Username ..... Password .....

☐ Email Accounts: ☐ Gmail ☐ Hotmail ☐ Outlook ☐ AOL ☐ [Other] .....

☐ Social Networking: ☐ Facebook ☐ LinkedIn ☐ Twitter ☐ Pinterest ☐ [Other] .....

☐ Telecommunications: ☐ Skype ☐ AOL AIM ☐ [Other] .....

☐ Digital Photography: ☐ Snapfish ☐ Shutterfly ☐ [Other] .....

☐ Credit Cards: ☐ Visa ☐ Mastercard ☐ American Espress ☐ [Other] .....

☐ E-commerce Accounts: ☐ PayPal ☐ eBay ☐ Craigslist ☐ Amazon ☐ Other]

☐ Website Domain Name, Address and Password: .....

☐ Other Online Accounts: ☐ Flickr ☐ YouTube ☐ [Other] .....

DEBTS

CREDITOR	AMOUNT	PROPERTY SECURED

Do you own any burial plots? Yes ☐ No ☐ If yes, please provide the name and address of the cemetery, and attach copy of deed(s).

Have you prepaid your funeral? Yes ☐ No ☐ If yes, provide the name and address of funeral home, and attach copy of funeral contract.

Are you a veteran? Yes ☐ No ☐ If yes, provide the following:

Dates of Military Service _____
VA Claim Number _____
Branch of Service _____

Please describe any veteran's benefits you are now receiving:

_____

_____

IV. YOUR LAST WILL AND TESTAMENT.

PRIMARY BENEFICIARIES

Identify those to whom you want to leave your estate, and in what amounts.

Name	Address	Relationship	Percentage or Amount of Estate

Please explain any special medical or financial needs of any persons listed above:_____

ALTERNATIVE BENEFICIARIES

If the persons identified above as Primary Beneficiaries die before you, who do you want to inherit your estate instead?

Name	Address	Relationship	Percentage of Estate or Amount

Please explain any special medical or financial needs of any persons listed above:_____

_____

SPECIFIC GIFTS

Do you wish to make any specific gifts of tangible personal property, real estate, cash, securities, etc?

Specific Gift	Name Of Beneficiary	Address	Relationship

CHARITIES YOU WISH TO BENEFIT

Name of Charity	Address	Percentage of Estate or Amount

Children:

If you have children, do you wish to treat all of your children equally? Yes ☐ No ☐ If no, why not? _____
After your death, at what age do you want distribution to your children? ___
(e.g., a typical plan provides for 1/2 at age 23, 1/2 at age 28, or immediate)

Grandchildren:

Do you wish to leave a specific amount of money or a percentage of your estate to your grandchildren? Yes ☐ No ☐ If yes, how much? _____
Do you wish to treat all of your grandchildren equally? Yes ☐ No ☐ If no, why not? _____
At what age do you want distributions to your grandchildren? _____
(e.g., a typical plan provides for 1/2 at age 23, 1/2 at age 28, or immediate)

EXECUTORS

Who do you want to be the executor of your estate? Please list alternate people in case the person you name is unable or unwilling to be the executor.

Name	Address	Relationship	Age

TRUSTEES

Who do you want to manage any trusts that may be established now, or under your will? Please list alternate people in case the person you name is unable or unwilling to serve.

Name	Address	Relationship	Age

GUARDIANS

Who do you want to designate in your will as caretakers for people who may be minor children or incompetent? Please list alternatives.

Name	Address	Relationship	Age

V. LIVING WILLS.

A living will and health care proxy address several important health care issues. These documents inform medical providers of your wishes concerning your care, and authorize someone, as your agent, to make health care decisions for you. Add any personal matters of concern in the margins or in attached pages.

LIVING WILL INFORMATION

Doctor: (Name and Address) _____
Priest/Rabbi/Spiritual Advisor: (Name and Address) _____
Agent: _____
Alternate Agent: _____

Medical procedures (When you have an incurable disease, are in a long-term coma or are severely demented): [ ] May be withheld [ ] May not be withheld [ ] Agent may decide [ ] Other: _____

Nutrition/Hydration: [ ] May be withheld [ ] May not be withheld [ ] Agent may decide [ ] Other: _____

Pain Medication/Treatment: [ ] Should be provided [ ] May be withheld
[ ] Agent may decide [ ] Other: _____

Do you direct that all health care decisions made by your Agent on your behalf be consistent with the teachings of your religion or faith? [ ] Yes [ ] No If yes, please describe your religion:_____

Autopsy: [ ] May be performed [ ] May not be performed
[ ] Other: _____

Organ Donation: [ ] Yes[ ] No [ ] Other: _____

Disposition of Remains: [ ] Cremation [ ] Burial
[ ] Agent May Decide
[ ] As described in my Will or funeral contract
[ ] Other (specify): _____

Memorial Service: [ ] Yes, in accordance with _____ religion
[ ] No [ ] Other: _____

Euthanasia: [ ] Agree [ ] Disagree

Do Not Resuscitate Orders: [ ] May be established [ ] Other: _____
[ ] May not be established

Other Personal Preferences:_____

VI. POWER OF ATTORNEY.

A durable power of attorney is a critical component of any estate plan. It provides the authority to a designated person to act on your behalf in the event you are disabled, or otherwise unable to act.

POWER OF ATTORNEY INFORMATION

Please indicate, in order, the names, addresses and relationships of persons to serve as your agents.

Name	Address	Relationship	Age

Answer the following questions as best you can. Add any additional concerns or points in the margins:

Should agents have authority to act: [ ] Only if you are disabled (i.e., springing); or [ ] Should their authority be immediate (i.e., durable)?

Should multiple agents be required to act jointly? Yes ☐ No ☐

Should the last agent be given the authority to appoint a successor so that the power remains valid? Yes ☐ No ☐

Should agents be given compensation? Yes ☐ No ☐

Should agents have power over retirement assets? Yes ☐ No ☐

Do you want your agent(s) to be able to make gifts of your property if necessary for tax reasons or to protect your assets?: Yes ☐ No ☐

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

☐ No restrictions, I trust my agent(s) to make the right decision.

☐ My restrictions are:_____

VII. GIFTS.

Have you ever filed a federal gift tax return? Yes ☐ No ☐ If yes, please provide details: _____

VIII. PRIOR ESTATE DOCUMENTS.

	Date Made	Location of Original
Last Will and Testament	_____	
Durable Power of Attorney	_____	
Living Will/Health Care Proxy	_____	_____
Trust Instruments	_____	_____

(Provide copies of all the previously prepared estate documents)

IX. MISCELLANEOUS.

Have you considered Long Term Care Insurance to cover the catastrophic costs of long-term care? Yes ☐ No ☐.

Is any other information I should be aware of? Yes ☐ No ☐ If yes, please explain: _____

X. REFERRAL.

By whom were you referred to this office?
Name _____
Street Address_____
City_____ State_____ Zip_____
Referral is:
___ Attorney
___ Financial Planner
___ Previous Client of the Law Office of Donald D. Vanarelli
___ Other_____
Have you visited our website at www.dvanarelli.com? Yes ☐ No ☐
If yes, do you have any ideas for improving our website? If so, please discuss. _____
_____

XI. CERTIFICATION.

I understand that the recommendations and advice which you give, and any documents you prepare, will be based on the accuracy and completeness of the disclosures made herein. **Thus, I certify that the information provided is true and correct in all respects to the best of my knowledge and belief.**

_____
Client