

DONALD D. VANARELLI ♦♦♦♦  
WHITNEY W. BREMER  
CHEN LI ♦♦  
*Of Counsel*  
ERIC A. STRULOWITZ

*\* Certified Elder Law Attorney  
By The National Elder Law Foundation  
Accredited by The American Bar Association*

*• Also Admitted in New York  
▪ Accredited Professional Mediator  
• Accredited Veterans Attorney*



242 ST. PAUL STREET, WESTFIELD, NJ 07090

TELEPHONE: 908-232-7400

FACSIMILE: 908-232-7214

E-MAIL: [dvanarelli@dvanarelli.com](mailto:dvanarelli@dvanarelli.com)

WEB SITE: [www.dvanarelli.com](http://www.dvanarelli.com)

PROVIDING:  
ELDER LAW SERVICES  
ESTATE PLANNING AND TRUST ADMINISTRATION  
MEDICAID AND PUBLIC BENEFITS PLANNING  
SPECIAL NEEDS PLANNING  
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COLLABORATIVE LAW  
MEDIATION SERVICES  
SOCIAL SECURITY DISABILITY APPEALS

## CONFIDENTIAL CLIENT QUESTIONNAIRE for ESTATE, ENTITLEMENT AND ASSET PROTECTION PLANNING

This questionnaire is intended to elicit the basic information we need to help you with estate and public benefits 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 \_\_\_\_\_

1. Name of Person Completing Questionnaire: \_\_\_\_\_

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

Tel. Home: \_\_\_\_\_ Tel. Bus: \_\_\_\_\_

Cell Phone No. \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Fax: \_\_\_\_\_ Your Relationship to Elder: \_\_\_\_\_

Purpose of This Visit? \_\_\_\_\_

### PART A: REFERRAL

2. 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
- Website
- Other \_\_\_\_\_

3. Have you visited our website at [www.dvanarelli.com](http://www.dvanarelli.com)? Yes  No   
If yes, do you have any ideas for improving our website? If so, please discuss.

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### PART B: PERSONAL INFORMATION

4. Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Date of birth: \_\_\_\_\_

SSN: \_\_\_\_\_

Driver's License No. and  
Name of Issuing State: \_\_\_\_\_

U. S. citizen?: \_\_\_\_\_  Yes  No

Veteran?:  Yes  No      Branch of Service: \_\_\_\_\_      Dates of Service: \_\_\_\_\_

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

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### PART C: MEDICAL INFORMATION

6. **HEALTH**

Diagnosis \_\_\_\_\_

If you are already in a nursing home:

Name of Nursing Home \_\_\_\_\_

Date Entered \_\_\_\_\_

Monthly Cost \_\_\_\_\_ Funding Source(s) \_\_\_\_\_



The nursing home is paid through \_\_\_\_\_ (month/year).

Were you admitted to a hospital or other medical institution immediately prior to your admission to the nursing home? Yes  No . If yes, please provide the name and address of the institution and the admission date: \_\_\_\_\_

7. **PHYSICIAN**

Full Name of Primary Physician \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PART D: LIVING ARRANGEMENTS**

8.	Place Where You Live	Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Nursing home	
<input type="checkbox"/>	Other:	

9. List the names of all persons who provide assistance to or caregiving for you:

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

10. Does a child, parent, sibling, or other family member currently live in your home? Yes  No  If yes, identify who lives with you, how long they have lived with you, and whether they own any part of your home: \_\_\_\_\_

\_\_\_\_\_

11. If you answered yes to the question above, is any portion of your income used to provide all or a portion of their support? Yes  No .



**PART E: FAMILY MEMBERS**

**12. CHILDREN**

(Include children who predeceased you, if any.)

Name	Address	Age	Sex	Telephone Number	Spouse's Name

Relationship:  Natural child  Adopted  Stepchild  Child born out of wedlock

**13. GRANDCHILDREN**

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

- 14. Are all your children / grandchildren in good health? Yes  No
- 15. Are any of your children / grandchildren blind? Yes  No
- 16. Are any of your children / grandchildren disabled? Yes  No
- 17. Do any of your children / grandchildren receive SSI, Medicaid or other government benefits based upon financial need? Yes  No
- 18. 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
- 19. Do you trust your children's spouses? Yes  No
- 20. Are you concerned about potential litigation against you? Yes  No

**PART F: MONTHLY INCOME**

21. Source of Income

Gross Salary or Wages \_\_\_\_\_

Social Security (include Medicare Part B Premiums) \_\_\_\_\_



Retirement Benefits \_\_\_\_\_

Interest \_\_\_\_\_

Dividends \_\_\_\_\_

Veterans' Benefits \_\_\_\_\_

Pension (Gross Amount) \_\_\_\_\_

Annuity \_\_\_\_\_

Alimony \_\_\_\_\_

Rental Income \_\_\_\_\_

Other \_\_\_\_\_

**TOTAL INCOME** \_\_\_\_\_

**PART G: ASSETS**

**22. REAL ESTATE (Please provide copies of current tax bills and deeds)**

Street Address, City, State	Owner*	Fair Market Value	Assessed Value (Obtain from Tax Bill)	Outstanding Loans

\* JT=Joint Tenant, TC=Tenants-in-Common

23. Homeowner's Insurance Company: \_\_\_\_\_

**24. BANK ACCOUNTS (Attach separate sheet(s) if necessary)**

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

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



**25. IRAs, KEOUGHS, 401(K) RETIREMENT PLANS**

Name and Address of Plan Custodian	Owner	Account Number	Primary/Alternate Beneficiary	Value

**26. MUTUAL FUNDS (Please list all mutual funds and provide statements)**

Company Name and Address	Owner	Account Number	Fair Market Value

**27. STOCKS (Non-Mutual Funds; Do Not Include IRAs)**

Name of Stock	Owner	Number of Shares	Purchase Date	Cost	Current Market Value

**28. BONDS AND TREASURY NOTES (Non-Mutual Funds)**

List all US Savings Bonds, corporate bonds, municipal bonds, treasury notes, etc.	Owner	Face Value



**29. LIFE INSURANCE and ANNUITY CONTRACTS (Please provide copies)**

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

**30. BUSINESS INTERESTS**

Company	Owner	Type*	Percentage Ownership	Value	Buy/Sell Agreement

\*Corporation (C), Sole Proprietorship (SP), Partnership (P), Limited Liability Company (LLC)

**31. VALUABLE PERSONAL PROPERTY: AUTOMOBILES, JEWELRY, COLLECTIONS, ETC.**

ASSET	OWNER	VALUE

32. Do you expect to inherit significant property? Yes  No . If yes, please explain: \_\_\_\_\_

33. Do you own a safe deposit box? Yes  No . If yes, provide the box number(s), location(s) and contents: \_\_\_\_\_

34. Do you or your spouse own any burial plots? Yes  No . If yes, please provide the name and address of the cemetery, and attach copies. \_\_\_\_\_

35. Have you or your spouse prepaid your funeral? Yes  No . If yes, please provide name and address of funeral home, and attach copies of funeral contract.

**36. Public Benefits and Community Services**

In addition to Social Security and Medicare, are you receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, PAAD, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group



services, property tax relief, home weatherization, and drug company discount card programs.  Yes  No If yes, please list them below:

Provider	Form of assistance

**37. 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 Express  [Other] .....
- E-commerce Accounts:  PayPal  eBay  Craigslist  Amazon  Other]
- Website Domain Name, Address and Password: .....
- Other Online Accounts:  Flickr  YouTube  [Other] .....

**38. DEBTS**

(Include real estate taxes, insurance, utilities, credit card debt, personal loans, lines of credit, informal loans from family members, etc. (Do not include the mortgages listed above.)

CREDITOR	AMOUNT	PROPERTY SECURED





39. Do you need to make improvements or repairs on your home? Yes  No . If yes, describe the improvements needed, and estimated costs: \_\_\_\_\_

40. Do you need a new car? Yes  No .

41. Do you need or want any household items or personal effects? Yes  No . If yes, set forth items and cost: \_\_\_\_\_

#### **PART H: MONTHLY HOUSING EXPENSES**

42. Please provide the following *monthly* housing expenses:

\$ \_\_\_\_\_ Mortgage/Rent

\$ \_\_\_\_\_ Real Estate Taxes

\$ \_\_\_\_\_ Water

\$ \_\_\_\_\_ Sewer

\$ \_\_\_\_\_ Utilities (Heat, Electric & Telephone)

\$ \_\_\_\_\_ Homeowner's Insurance Premium

\$ \_\_\_\_\_ Condominium Fees

\$ \_\_\_\_\_ **Monthly Total**

#### **PART I: MONTHLY NON-SHELTER LIVING EXPENSES**

43. Please provide the following *monthly* non-shelter living expenses:

\$ \_\_\_\_\_ Food

\$ \_\_\_\_\_ Medical

\$ \_\_\_\_\_ Clothing

\$ \_\_\_\_\_ Transportation (including auto insurance)

\$ \_\_\_\_\_ Home Maintenance

\$ \_\_\_\_\_ Life Insurance Premiums



\$ \_\_\_\_\_ Health Insurance Premiums

\$ \_\_\_\_\_ Cable TV

\$ \_\_\_\_\_ Other

\$ \_\_\_\_\_ **Monthly Total**

**PART J: ESTATE DOCUMENTS**

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

**(Please provide copies of all estate documents identified above.)**

45. I am the legal guardian of: \_\_\_\_\_

46. I have been appointed as agent under a power of attorney: Yes  No

*Provide the information requested below **ONLY** if you do not have estate documents or you want to make changes to the documents in our planning process. If not, skip to Part K.*

**47. YOUR LAST WILL AND TESTAMENT.**

**PRIMARY BENEFICIARIES.**

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

Name	Address	Relationship	Percentage of Estate or Amount

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 or your spouse 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

**EXECUTORS.**

Who do you want to be the executor of your estate? List alternates in case the person you name is unable or unwilling to serve.

Name	Address	Relationship	Age

**TRUSTEES.**

Who do you want to manage any trusts that are established? List alternates in case the person you name is unable to serve.

Name	Address	Relationship	Age

**GUARDIANS.**

Who do you want to designate as caretakers for people who are minors or incompetents? List alternatives in case the person you name is unable or unwilling to serve. You can designate people to serve together (e.g., husband and wife, etc.).

Name	Address	Relationship	Age

**48. 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 when you cannot do so. In addition to the information requested, you can add any personal matters of concern in the margins or on attached pages.

Doctor: (Name and Address) \_\_\_\_\_

Priest/Rabbi/Spiritual Advisor: (Name and Address) \_\_\_\_\_

Agents: \_\_\_\_\_



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

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

Organ Donation:  Yes  No

Disposition of Remains:  Cremation  Funeral/Burial  Agent May  
Decide  
 As described in my Will, funeral contract, or other  
Specify: \_\_\_\_\_

Memorial Service:  Yes, in accordance with \_\_\_\_\_ religion  
 Yes, with the following songs, readings, people, etc.

\_\_\_\_\_  
 No  Other: \_\_\_\_\_

Euthanasia:  Agree  Disagree

Do Not Resuscitate Orders:  May be established  May not be established

Other Personal Preferences: \_\_\_\_\_



**49. POWER OF ATTORNEY.**

A power of attorney (POA) is a critical component of any estate plan. A POA provides authority to a designated person to manage your financial affairs on your behalf in the event you are disabled, or otherwise unable to act. 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 additional concerns in the margins:**

Should agents have authority to act:  Only if you are disabled (i.e., springing); or  immediately (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?  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 they believed that was 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: \_\_\_\_\_

**PART K: GIFTS**

50. Have you made any gifts or transfers in excess of \$1,000/year to anyone within the past 60 months? Yes  No  If yes, please provide detthe following information:

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Did you ever file a federal gift tax return? Yes  No . If yes, please provide details:

\_\_\_\_\_

\_\_\_\_\_



**58. INSURANCE**

<b>Medicare/Private Insurance</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Company: _____ Address: _____	<b>Medicare/Private Insurance</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Company: _____ Address: _____
<b>Other: Accident, Liability, Etc.</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Company: _____ Address: _____	<b>Other: Accident, Liability, Etc.</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Company: _____ Address: _____

51. Do you own Long-Term Care Insurance (LTCI)? Yes  No  Have you considered LTCI to cover the catastrophic costs of long-term care? Yes  No .

52. Do you believe there is any other information I should be aware of? Yes  No . If yes, please explain: \_\_\_\_\_

**PART L: 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**