

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

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

II. BACKGROUND AND FAMILY INFORMATION

1. Name: _____
D.O.B.: _____ Last 4 digits of SS# _____
Phone Number(s): (H) _____ (C) _____ (O) _____
E-mail _____ Current Address: _____
Are you a United States Citizen? Yes No ; resident alien __ (Resident Alien # _____);
other (please explain: _____).

2. Marital Status: Widowed _____ Divorced _____ Single _____
Name of former spouse: _____
If widowed, please provide date, county and state of spouse's death: _____
_____. Date of Marriage: _____

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

Include Deceased Children

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

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

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

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Adopted/Half-blood _____

4. Grandchildren:

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

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

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

5. If no surviving children, list names of your living siblings.

Name\Age _____
Relationship _____
Address _____
Phone # _____

Name\Age _____
Relationship _____
Address _____
Phone # _____

6. Names of living parents:

Name\Age _____
Relationship _____
Address _____
Phone # _____

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

Medicare/Private Insurance
Company: _____
Address: _____
Medicaid
Medicaid Program: _____
Medicaid ID & Case No.: _____

Medicare Supplement
Company: _____
Address: _____
Long Term Care Insurance
Company: _____
Address: _____

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Other, Cancer, Accidental

Company: _____

Address: _____

IV. PERSONAL INFORMATION

1. Have you ____ (or your former/deceased spouse ____) used your exemption from capital gains taxes on the sale of a residence in the last 5 years? _____

2. Have arrangements been made for the disposition of your body at death (burial plot, funeral contract, etc.)? ____ Are they paid for? ____ Please describe the arrangements and who they are with: _____

3. Are you ____ (or your former/deceased spouse ____) a veteran? ____ If yes, did you serve in wartime? Do you currently receive any benefits? __ If yes, please explain: _____

4. Are you at risk because of a medical condition or family history of becoming seriously ill or disabled or, are you presently experiencing an illness? Yes No If yes please explain: _____

5. Are you on hospice? Yes No If yes, who is your provider? _____
Name of contact person: _____

6. 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? Yes No If yes, please explain. _____

V. ASSETS

1. Real Estate located in Florida:

Address: _____

Fair Market Value: _____
(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 (or any other real estate located in Florida):

Address: _____

Fair Market Value: _____
(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)

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3. Automobiles, Mobile Homes, Recreational Vehicles, Boats:
Make/Model Year Fair Marker Value Liens Owner

4. Stocks, securities, bonds, and investments:

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

5. Retirement and pension plans (include IRAs, 401(k)s and 529b):

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
Taking minimum distribution Yes No Amount \$ _____ Frequency _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____

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Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
Taking minimum distribution Yes No Amount \$ _____ Frequency _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
Taking minimum distribution Yes No Amount \$ _____ Frequency _____
First Beneficiary: _____; Second Beneficiary: _____

6. Bank Accounts (i.e. checking, savings, money market, etc.):

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits Account #: _____
Name of Owner: _____
First Beneficiary: _____; Second Beneficiary: _____

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 _____

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

8. Annuities:

Asset: _____ Value: _____ Last 4 digits Account #: _____
Name & Address of Co. _____
Name of Owner: _____ Name of Annuitant: _____
When does it mature? _____; interest rate _____
Are you receiving payments? Yes No Amount: \$ _____ Frequency: _____
Are there survivorship benefits and who is the beneficiary: _____.

Asset: _____ Value: _____ Last 4 digits Account #: _____
Name & Address of Co. _____
Name of Owner: _____ Name of Annuitant: _____
When does it mature? _____; interest rate _____
Are you receiving payments? Yes No Amount: \$ _____ Frequency: _____
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.

Social Security \$ _____

Employment \$ _____

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Pensions \$ _____ From: _____

\$ _____ From: _____

IRA's \$ _____

Annuities \$ _____

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

Dividends on Stocks and Bonds: \$ _____

VA A & A \$ _____

VA - Other \$ _____

Other (i.e. rent) \$ _____

TOTAL INCOME: \$ _____

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: \$ _____

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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.

Have you made any gifts or transfers (such as Christmas, birthdays, charities, tithing etc.), of any amount, to any individuals or charities 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: _____

X. LEGAL DOCUMENTS

A. Last Will & Testament:

1. Name of Personal Representative/Relationship: _____
(Florida Resident or related by blood or marriage)
Address of Personal Representative: _____

Name of Successor Personal Representative/Relationship: _____
(Florida Resident or related by blood or marriage)
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 _____ Share _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____:

Name\Age _____ Relationship _____ Share _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____:

Name\Age _____ Relationship _____ Share _____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share: _____
_____:

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

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

Charity Name _____ Share _____
Address _____ Phone # _____

Charity Name _____ Share _____
Address _____ Phone # _____

3. Is there a pre or post-nuptial agreement? Yes No

4. . If you have minor children:

a. Do you wish to name a pre-need guardian? Yes No
I wish to name: _____ as Guardian of Property; and
_____ as Guardian of Person.

b. Do you wish to name a surrogate to make health care decisions for your minor child on your behalf if you are unavailable? Yes No
I wish to name _____ as my primary surrogate; and
_____ as my secondary surrogate.

5. Do you wish to name a preneed guardian for yourself? Yes No
I wish to name: _____ as Guardian of Property; and
_____ as Guardian of Person.

6. If you have digital devices (computers, mobile phones, tablets) and digital assets (data, photographs, and videos found in digital media including, but not limited to, email accounts, social media accounts, financial accounts, blogs, and websites whether in individual name, through a pseudonym, or anonymously):

Do you wish to authorize the Personal Representative to access any and all digital assets and devices?
Yes No
If yes, which digital assets: _____

Do you wish to authorize the Personal Representative to access and discontinue and dispose of any and all digital assets and devices?
Yes No
If yes, which digital assets: _____

Do you wish to authorize the Personal Representative to access and distribute any and all digital assets?
Yes No
If yes, which digital assets: _____
To whom: _____

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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? Yes No

****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*

1. Name/Relationship: _____
Address: _____

2. Name/Relationship: _____
Address: _____

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 and fund 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 (i.e. power of appointment; inheritance)

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 statutory rights (homestead; family allowance; elective share)

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

If yes, rate of compensation: _____

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/Relationship: _____

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Address: _____
Home _____ Office _____ Cell _____

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

3. My health care surrogate is authorized to make health care decisions for me:
a. Immediately _____ b. Only when I am incapacitated _____

4. My health care surrogate is authorized to access my health information:
a. Immediately _____ b. Only when I am incapacitated _____

5. Do you want your health care surrogate to be compensated? Yes No
If yes, rate of compensation: _____

6. 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: Yes No **OR**

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only the following organs or parts: _____.

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

b) I wish give my body for anatomical study, if needed, for the purpose of transplantation, therapy, medical research, or education: Yes No

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/Relationship: _____

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

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

Do you want your Trustee to be compensated?

If yes, rate of compensation _____

5. Name & address of designated representative/Relationship (to receive accountings, reports, etc. in the event of your incapacity): _____

6. Name & address of first successor designated representative/Relationship: _____

7. If you have digital devices (computers, mobile phones, tablets) and digital assets (data, photographs, and videos found in digital media including, but not limited to, email accounts, social media accounts, financial accounts, blogs, and websites whether in individual name, through a pseudonym, or anonymously):

Do you wish to authorize the Trustee to access any and all digital assets and devices?

Yes No

If yes, which digital assets: _____

Do you wish to authorize the Trustee to access and discontinue and dispose of any and all digital assets and devices?

Yes No

If yes, which digital assets: _____

Do you wish to authorize the Trustee to access and distribute any and all digital assets and devices?

Yes No

If yes, which digital assets: _____

To whom: _____

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8. Disposition upon your death: _____

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

10. Credit shelter trust: _____

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 remains or cremains as well as take steps to enforce any anatomical gift you desire.

b. If yes, identify the primary authorized representative:

Name/Relationship: _____

Address: _____

c. If yes, identify the successor authorized representative:

Name/Relationship: _____

Address: _____

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

e. Detail any special wishes for your final arrangements, memorial service, etc. _____

f. 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.

Signature: _____

Print Name: _____

Date: _____