

STEPHANIE L. SCHNEIDER, P.A.
ESTATE, HEALTH CARE AND MEDICAID PLANNING QUESTIONNAIRE
DOMESTIC PARTNERS

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

II. BACKGROUND AND FAMILY INFORMATION

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

2. Partner 2 Name: _____
D.O.B.: _____ Last 4 digits of SS# _____
Phone Number(s): (H) _____ (C) _____ (O) _____
E-mail _____
Current Address: _____
If deceased, date, county and state of death: _____.
Are you a United States Citizen? Yes No ; resident alien __ (Resident Alien # _____);
other __ (please explain: _____).

3. Date Relationship Began: _____ Civil Union Yes No Married Yes No
Domestic Partnership Registration Yes No **State** _____ **Date** _____

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

Included Deceased Children

	<u>PARTNER 1</u>	<u>PARTNER 2</u>
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____
Email	_____	_____
Adopted/Half-blood	_____	_____

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

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

5. 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 _____

If no surviving children, list names of siblings or nieces, nephews, cousins for each partner.

PARTNER 1

PARTNER 2

Name\Age _____
Relationship _____
Address _____
Phone # _____

Name\Age _____
Relationship _____
Address _____
Phone # _____

Name\Age _____
Relationship _____
Address _____
Phone # _____

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7. Names of living parents:

	<u>PARTNER 1</u>	<u>PARTNER 2</u>
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:

	<u>PARTNER 1</u>	<u>PARTNER 2</u>
<u>Medicare/Private Insurance</u>		
Company: _____		_____
Address: _____		_____
<u>Medicare Supplement</u>		
Company: _____		_____
Address: _____		_____
<u>Medicaid</u>		
Medicaid Program: _____		_____
Medicaid ID & Case No. _____		_____
<u>Long Term Care Insurance</u>		
Company: _____		_____
Address: _____		_____
<u>Other, Cancer, Accidental</u>		
Company: _____		_____
Address: _____		_____

IV. PERSONAL INFORMATION

1. Have you _____ or your partner _____ 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 (burial plot, funeral contract, etc.)? _____ Are they paid for? _____ Please describe the arrangements and who they are with: _____
_____.
3. Are you _____ or your partner _____ a veteran? ___ If yes, did the veteran serve in wartime? ___ Does the veteran currently receive any benefits? ___ If yes, please explain: _____
_____.
4. Are you _____ or your partner _____ 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: _____
_____.

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5. Are you or your partner on hospice? Yes No If yes, who is the 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? 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)

3. Automobiles, Mobile Homes, Recreational Vehicles, Boats:

<u>Type</u>	<u>Year</u>	<u>Fair Market Value:</u>	<u>Liens</u>	<u>Owner</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Stocks, securities, bonds, and investments:

Asset: _____

Name & Address of Co. _____

Value: _____ Last 4 digits of Account #: _____

How is it titled: _____

First beneficiary: _____ Second beneficiary: _____

Asset: _____

Name & Address of Co. _____

Value: _____ Last 4 digits of Account #: _____

How is it titled: _____

First beneficiary: _____ Second beneficiary: _____

Asset: _____

Name & Address of Co. _____

Value: _____ Last 4 digits of Account #: _____

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How is it titled: _____
First beneficiary: _____ Second beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits of Account #: _____
How is it titled: _____
First beneficiary: _____ Second beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits of Account #: _____
How is it titled: _____
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 of Account #: _____
How is it titled: _____
Taking minimum distribution Y-N: _____ Amount \$ _____ Frequency _____
First beneficiary: _____ Second beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits of Account #: _____
How is it titled: _____
Taking minimum distribution Y-N _____ Amount \$ _____ Frequency _____
First beneficiary: _____ Second beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits of Account #: _____
How is it titled: _____
Taking minimum distribution Y-N _____ 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 of Account #: _____
How is it titled: _____
First beneficiary: _____ Second beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits of Account #: _____
How is it titled: _____
First beneficiary: _____ Second beneficiary: _____

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Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits of Account #: _____
How is it titled: _____
First beneficiary: _____ Second beneficiary: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Last 4 digits of Account #: _____
How is it titled: _____
First beneficiary: _____ Second beneficiary: _____

7. Life insurance:

<u>PARTNER 1</u>	<u>PARTNER 2</u>
Name of Owner _____	_____
Name of Insured _____	_____
Name of Insurer _____	_____
Last 4 digits of Policy #: _____	_____
Face Value: _____	_____
Cash Surrender Value: _____	_____
Term or whole life: _____	_____
Beneficiary (ies): _____	_____

Name of Owner _____	_____
Name of Insured _____	_____
Name of Insurer _____	_____
Last 4 digits of Policy #: _____	_____
Face Value: _____	_____
Cash Surrender Value: _____	_____
Term or whole life: _____	_____
Beneficiary (ies): _____	_____

8. Annuities:

Asset: _____ Value: _____ Last 4 digits of 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 of 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):

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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.

	PARTNER 1	PARTNER 2	JOINT
<u>Social Security</u>	\$ _____	\$ _____	
<u>Employment</u>	\$ _____	\$ _____	
<u>Pensions</u>	\$ _____	\$ _____	
	From: _____	From: _____	
	\$ _____	\$ _____	
	From: _____	From: _____	
<u>IRAs</u>	\$ _____	\$ _____	
<u>Annuities</u>	\$ _____	\$ _____	
<u>Interest on Bank Accounts, Savings Accounts, C.D.'s:</u>			
	\$ _____	\$ _____	\$ _____
<u>Dividends on Stocks and Bonds:</u>			
	\$ _____	\$ _____	\$ _____
<u>Other (i.e. rent)</u>	\$ _____	\$ _____	\$ _____
<u>TOTAL INCOME:</u>	\$ _____	\$ _____	\$ _____

Which sources of income have a benefit for a surviving partner? _____

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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.

1. Have you or your partner made any gifts or transfers (such as Christmas, birthdays, charities, tithing etc.), of any amount, to any individuals or charities including the other partner within the last sixty (60) months?

Yes No ; If yes, complete the following:

PARTNER 1

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____

PARTNER 2

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____
Value: _____

Name of recipient: _____
Date of Gift: _____
Item: _____

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Value: _____

Value: _____

Name of recipient: _____

Name of recipient: _____

Date of Gift: _____

Date of Gift: _____

Item: _____

Item: _____

Value: _____

Value: _____

X. LEGAL DOCUMENTS

A. Last Will & Testament of Partner 1:

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: _____

_____.

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 # _____

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3. Is there a domestic partner agreement in place? Yes No

4. If you have minor children, do you wish to name a pre-need guardian? Yes No

If yes, complete the following statement. I wish to name: _____.

5. Do you wish to name a preneed guardian for yourself? Yes No .

If yes, complete the following statement. I wish to name: _____.

6. If you have 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?

Yes No If yes, which digital assets: _____

Do you wish to authorize the Personal Representative to discontinue and dispose of any and all digital assets?

Yes No If yes, which digital assets: _____

Do you wish to authorize the Personal Representative to distribute any and all digital assets?

Yes No If yes, which digital assets: _____

To whom: _____

B. Last Will & Testament of Partner 2:

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: _____

_____.

Name\Age _____ Relationship _____ Share _____

Address _____ Phone # _____

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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 domestic partner agreement in place? Yes No

4. If you have minor children, do you wish to name a pre-need guardian? Yes No
If yes, complete the following statement. I wish to name: _____.

5. Do you wish to name a preneed guardian for yourself? Yes No
If yes, complete the following statement. I wish to name: _____.

6. If you have 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?
Yes No If yes, which digital assets: _____

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

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

C. Durable Power of Attorney for Partner 1: If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship?

****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: _____

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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. powers 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 (i.e. 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. 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 Spouse 2: If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship?

****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 an inter vivos trust (i.e., revocable living trust)

Yes	No	Legal Authority
		Amend, modify, revoke or terminate a trust (trust must give agent this authority also)

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		Make a gift (subject to restrictions)			Create or change rights of survivorship
		Create or change a beneficiary designation on life insurance			Waive your right to be a beneficiary of a joint and survivor annuity, including under a retirement plan
		Create or change a beneficiary designation on other assets			
		Disclaim property to which you may be entitled			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
 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

E. Designation of Health Care Surrogate for Partner 1: 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: _____
 Address: _____
 Telephone: Office _____ Home _____ Mobile _____
2. Name of Alternate Surrogate: _____ Relationship: _____
 Address: _____
 Telephone: Office _____ Home _____ Mobile _____
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): _____

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F. Designation of Health Care Surrogate for Partner 2: 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: _____
Address: _____
Telephone: Office _____ Home _____ Mobile _____
2. Name of Alternate Surrogate: _____ Relationship: _____
Address: _____
Telephone: Office _____ Home _____ Mobile _____
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): _____

G. Living Will for Partner 1: 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

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If you answer "Yes" please complete the following:

- a) I wish to give any needed organs or parts: Yes No **OR**
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: _____.

H. Living Will for Partner 2: 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**
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: _____.

I. Living Trust for Partner 1(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 & relationship of Trustee or Co-Trustees: _____
_____.

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3. Name, address & relationship of first successor trustee: _____
_____.

4. Name, address & relationship of second successor trustee: _____
_____.

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

6. Name, address & relationship of first successor designated representative: _____
_____.

7. If you have 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?

Yes No

If yes, which digital assets: _____

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

Yes No

If yes, which digital assets: _____

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

Yes No

If yes, which digital assets: _____

To whom: _____

8. Disposition upon death of surviving partner: _____
_____.

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

J. Living Trust for Partner 2(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 & relationship of Trustee or Co-Trustees: _____
_____.

3. Name, address & relationship of first successor trustee: _____
_____.

4. Name, address & relationship of second successor trustee: _____
_____.

Do you want your Trustee to be compensated? Yes No

If yes, rate of compensation _____

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

6. Name, address & relationship of first successor designated representative: _____
_____.

7. If you have 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?

Yes No

If yes, which digital assets: _____

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

Yes No

If yes, which digital assets: _____

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

Yes No

If yes, which digital assets: _____

To whom: _____

8. Disposition upon death of surviving partner: _____
_____.

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

K. DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS (for Partner 1)

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 _____

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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: _____
_____.

L. DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS (for Partner 2)

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

f. Detail any restrictions you want to place on the representative's authority: _____
_____.

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.

Signature: _____

Print Name: _____

Date: _____

Signature: _____

Print Name: _____

Date: _____

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