

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

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

**II. BACKGROUND AND FAMILY INFORMATION**

1. Spouse 1's Name: \_\_\_\_\_  
Spouse 1's D.O.B.: \_\_\_\_\_ 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. Spouse 2's Name: \_\_\_\_\_  
Spouse 2's D.O.B.: \_\_\_\_\_ 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 and place of Marriage: \_\_\_\_\_.  
Is this a 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> Marriage: \_\_\_\_\_  
Did you previously have a civil union which was converted to marriage? \_\_\_\_\_
4. Children (please indicate whether any child is from a prior marriage). For minors, include their age:

**Included Deceased Children**

	<b><u>Spouse 1</u></b>	<b><u>Spouse 2</u></b>
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____

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Adopted/Half-blood \_\_\_\_\_

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

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

5. Grandchildren:

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

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

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

6. If no surviving children, list names of living siblings for each spouse.

**Spouse 1**

**Spouse 2**

Name\Age \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

Name\Age \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

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Name\Age \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

7. Names of living parents:

**Spouse 1**

**Spouse 2**

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:**

**Spouse 1**

**Spouse 2**

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 \_\_\_\_\_ and your 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 spouse \_\_\_\_\_ a veteran? \_\_\_\_\_ If yes, did the veteran serve in wartime? \_\_\_ Does the veteran currently receive any benefits? \_\_\_ If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

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4. Are you or your spouse 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 or your spouse 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:

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: \_\_\_\_\_

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: \_\_\_\_\_ Account #: \_\_\_\_\_

How is it titled: \_\_\_\_\_

First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

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Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ 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: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
Taking minimum distribution? Yes  No  Amount \$ \_\_\_\_\_ Frequency \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
Taking minimum distribution? Yes  No  Amount \$ \_\_\_\_\_ Frequency \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
Taking minimum distribution? Yes  No  Amount \$ \_\_\_\_\_ Frequency \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

6. Bank Accounts:

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Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

Asset: \_\_\_\_\_  
Name & Address of Co. \_\_\_\_\_  
Value: \_\_\_\_\_ Account #: \_\_\_\_\_  
How is it titled: \_\_\_\_\_  
First Beneficiary: \_\_\_\_\_; Second Beneficiary: \_\_\_\_\_

7. Life Insurance:

<u>Spouse 1</u>	<u>Spouse 2</u>
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:

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Asset: \_\_\_\_\_ Value: \_\_\_\_\_ 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: \_\_\_\_\_ 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.

	<b>Spouse 1</b>	<b>Spouse 2</b>	<b>JOINT</b>
<u>Social Security</u>	\$ _____	\$ _____	
<u>Employment</u>	\$ _____	\$ _____	
<u>Pensions</u>	\$ _____	\$ _____	
From:	_____	From: _____	
	\$ _____	\$ _____	
From:	_____	From: _____	
<u>IRA's</u>	\$ _____	\$ _____	





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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 spouse made any gifts or transfers (such as Christmas, birthdays, charities, tithing etc.), 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:

**Spouse 1**

**Spouse 2**

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: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

Name of recipient: \_\_\_\_\_  
Date of Gift: \_\_\_\_\_  
Item: \_\_\_\_\_  
Value: \_\_\_\_\_

**X. LEGAL DOCUMENTS**

A. Last Will & Testament of Spouse 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. Identify your beneficiary(ies), and their share (% or specific asset) 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 \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

Charity Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

3. Is there a pre or post-nuptial agreement? 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 Spouse 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. Identify your beneficiary(ies), and their share (% or specific asset) 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 \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

Charity Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

3. Is there a pre or post-nuptial agreement? 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 pre-need 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 Spouse 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: \_\_\_\_\_

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 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

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 property to which you may be entitled (i.e. power of appointment; inheritance)
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		Disclaim statutory rights (homestead; family allowance; elective share)
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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: \_\_\_\_\_  
 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   
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 Spouse 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: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_  
Relationship: \_\_\_\_\_

2. Name of Alternate Surrogate: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home: \_\_\_\_\_ Office \_\_\_\_\_ Cell \_\_\_\_\_  
Relationship: \_\_\_\_\_

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): \_\_\_\_\_

F. Designation of Health Care Surrogate for Spouse 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: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Office \_\_\_\_\_ Home \_\_\_\_\_  
Relationship: \_\_\_\_\_

2. Name of Alternate Surrogate: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Office \_\_\_\_\_ Home \_\_\_\_\_  
Relationship: \_\_\_\_\_

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 Spouse 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

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 Spouse 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 Spouse 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 of Trustee or Co-Trustees: \_\_\_\_\_  
\_\_\_\_\_

3. Name & address of first successor trustee: \_\_\_\_\_  
\_\_\_\_\_



4. Name & address of second successor trustee: \_\_\_\_\_  
\_\_\_\_\_

Do you want your Trustee to be compensated? Yes  No

If yes, rate of compensation \_\_\_\_\_

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

6. Name & address 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 second spouse: \_\_\_\_\_  
\_\_\_\_\_.

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

10. Credit shelter trust: \_\_\_\_\_

11. Marital deduction trust: \_\_\_\_\_.

J. Living Trust for Spouse 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 of Trustee or Co-Trustees: \_\_\_\_\_  
\_\_\_\_\_

3. Name & address of first successor trustee: \_\_\_\_\_  
 \_\_\_\_\_
4. Name & address of second successor trustee: \_\_\_\_\_  
 \_\_\_\_\_
5. Name & address of designated representative (to receive accountings, reports, etc. in the event of your incapacity): \_\_\_\_\_  
 \_\_\_\_\_
6. Name & address 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 second spouse: \_\_\_\_\_  
 \_\_\_\_\_
9. In the event a beneficiary predeceases or fails to survive you, who should receive that person's share: \_\_\_\_\_
10. Credit shelter trust: \_\_\_\_\_
11. Marital deduction trust: \_\_\_\_\_

**K. DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS (Spouse 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 \_\_\_\_\_

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** (Spouse 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.

Print Name: \_\_\_\_\_  
Date: \_\_\_\_\_

Print Name: \_\_\_\_\_  
Date: \_\_\_\_\_

F:\CLIENTS\Office-Forms\QUESTIONNAIRES and EXHIBIT LISTS\Questionnaire-Est&Medicaid-SSC.wpd