LAW OFFICE OF STEPHANIE L. SCHNEIDER, P.A.
PLANNING FOR VETERAN BENEFITS & MEDICAID QUESTIONNAIRE-MARRIED

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. Do you or your spouse have any other legal issues which our office should be aware of? ___.
   If yes, please explain: _____.

II. BACKGROUND INFORMATION

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

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

3. Date of Marriage:_____ Is this a 1st ,2nd ,3rd , or 4th Marriage:_____.

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

Include Deceased Children

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

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

HUSBAND **WIFE**

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

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:

HUSBAND **WIFE**

Medicare/Private Insurance
Company: _____ _____
Address: _____ _____
Medicare Supplement
Company: _____ _____
Address: _____ _____

Medicaid
Medicaid Program: _____ _____
Medicaid ID & Case No. _____ _____
Long Term Care Insurance
Company: _____ _____
Address: _____ _____
Other, Cancer, Accidental
Company: _____ _____
Address: _____ _____
Private Disability Insurance
Company: _____ _____
Address: _____ _____

IV. PERSONAL INFORMATION

1. Have you ____ and your spouse _____ used your exemption from capital gains taxes on the sale of a residence within the last 5 years? _____

2. Are you or your spouse a veteran?_____ Did the veteran serve in wartime? Yes □ No □
Do you currently receive any benefits? Yes □ No □; if yes, please explain:_____
_____

3. 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:_____
_____.

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. 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._____.

6. Is the client competent? Yes □ No □

7. Are you or your spouse on hospice? Yes □ No □; If yes, who is the provider?_____
Name of contact person: _____

V. MILITARY SERVICE: Indicate the time frame you served by 'yes' or 'no'.

	HUSBAND	WIFE
Mexican Border (5/9/16 - 4/5/17)	_____	_____
World War I (4/16/17 - 11/11/18)	_____	_____
WWI Russia (4/6/17-4/1/20 - 7/1/21)	_____	_____
World War II (12/7/41- 12/31/46)	_____	_____
Korean Conflict (6/27/50 - 1/31/55)	_____	_____

Vietnam Era (8/5/64- 5/7/75 _____ _____

Vietnam (2/28/61 - 8/5/64) _____ _____

Persian Gulf War (8/2/90 - ?) _____ _____

1. Did you receive an Honorable Discharge? Yes ☐ No ☐

2. Did you have 90+ days of active duty? Yes ☐ No ☐

3. Was at least 1 day during wartime? Yes ☐ No ☐

4. Do you require care or assistance on a regular basis to protect you from dangers in your daily environment? Yes ☐ No ☐

5. Do you have a current medical condition that may have been caused by an event during your service? Yes ☐ No ☐

6. Did you have a medical condition prior to entering the service that may have been aggravated since your service? Yes ☐ No ☐

Do you now receive service connected compensation for this aggravated condition? Yes ☐; $_____ No ☐

7. Were your service records documented with a medical condition or, symptom caused during your service? Yes ☐ No ☐

8. Do you have a deceased child who was a veteran? Yes ☐ No ☐

9. Were you dependent upon your deceased child for financial support? Yes ☐ No ☐

VI. ASSETS

1. Your home 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. Other real estate (other than your home) located in or 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)

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

Make/Model	Year	Fair Market Value	Liens	Owner

____

____

4. Stocks, securities, bonds, and investments:

Asset: ____
Name & Address of Co. ____
Value: __________ Account #:______________________
Name of Owner:____
First beneficiary:______________________ Second beneficiary:_________________________

Asset: ____
Name & Address of Co. ____
Value: __________ Account #:______________________
Name of Owner:____
First beneficiary:______________________ Second beneficiary:_________________________

Asset: ____
Name & Address of Co. ____
Value: __________ Account #:______________________
Name of Owner:____
First beneficiary:______________________ Second beneficiary:_________________________

Asset: ____
Name & Address of Co. ____
Value: __________ Account #:______________________
Name of Owner:____
First beneficiary:______________________ Second beneficiary:_________________________

Asset: ____
Name & Address of Co. ____
Value: __________ 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: __________ Account #:______________________
Name of Owner:____
Taking minimum distribution Y-N:______Amount $_________Frequency________
First beneficiary:______________________ Second beneficiary:_________________________

Asset: ____
Name & Address of Co. ____
Value: __________ Account #:______________________
Name of Owner:____
Taking minimum distribution Y-N_____Amount $__________ Frequency_______
First beneficiary:______________________ Second beneficiary:_________________________

Asset: ____
Name & Address of Co. ____

Value: _____ 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: _____ Account #:_____
Name of Owner:_____
First beneficiary:_____ Second beneficiary:_____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
Name of Owner:_____
First beneficiary:_____ Second beneficiary:_____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
Name of Owner:_____
First beneficiary:_____ Second beneficiary:_____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
Name of Owner:_____
First beneficiary:_____ Second beneficiary:_____

7. Life Insurance:

	HUSBAND	WIFE
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:

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: $ _____

VII. 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.

	HUSBAND	**WIFE**	**JOINT**
Social Security	$_____	$_____	$_____
VA Disability	$_____	$_____	$_____
VA DIC	$_____	$_____	$_____
Employment	$_____	$_____	$_____

Pensions $_____ $_____ $_____
From: _____ From: _____

$_____ $_____ $_____
From: _____ From: _____

IRA's $_____ $_____ $_____

Annuities $_____ $_____ $_____

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

$_____ $_____ $_____

Dividends on Stocks and Bonds:

$_____ $_____ $_____

Other (i.e. rent) $_____ $_____ $_____

TOTAL INCOME:
$_____ $_____ $_____

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

VIII. 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: $_____

IX. MONTHLY LIABILITIES

Mortgages: $_____
Notes to banks: $_____
Notes to others: $_____
Unpaid medical: $_____

Charge card bills: $_____

Other: $_____

TOTAL MONTHLY LIABILITIES: $_____

X. UNREIMBURSED MEDICAL EXPENSES. Identify those expenses you have already paid that are not covered by insurance. Focus on expenses that are recurring (indicate those that are infrequent). Identify the amount paid and to whom.

1. Health insurance premiums (Medicare; long term care):_____
_____

2. Over the counter medicines taken at doctor's direction: _____
_____

3. Mechanical & electronic devices:_____
_____

4. Adult day care center (i.e. Alzheimer's program):_____
_____

5. Nursing home or other facility:_____
_____

6. In home attendant (aide) that provides some medical or nursing services: _____
_____

7. Assisted living facility: _____
_____

8. Prescriptions: _____
_____

XI. TRANSFERS OF ASSETS. THIS INFORMATION MUST BE COMPLETED IN FULL.

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:

HUSBAND	**WIFE**
Name of recipient:_____	Name of recipient:_____
Date of Gift:_____	Date of Gift:_____
Item: _____	Item: _____
Value: _____	Value: _____
Name of recipient:_____	Name of recipient:_____
Date of Gift:_____	Date of Gift:_____
Item: _____	Item: _____
Value: _____	Value: _____
Name of recipient:_____	Name of recipient:_____

Date of Gift:________________________ Date of Gift:________________________
Item: ________________________ Item: ________________________
Value: ________________________ Value: ________________________

XII. What is the name, address and phone number of your primary care physician?
____
____

XIII. 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: ____

LEGAL DOCUMENTS

A. Last Will & Testament of Husband:

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________________________
Address ________________________ Phone # ________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:________________________
________________________.

Name\Age________________________ Relationship________________________
Address ________________________ Phone # ________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:________________________
________________________.

Name\Age________________________ Relationship________________________
Address ________________________ Phone # ________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:________________________
________________________.

Name\Age________________________ Relationship________________________
Address ________________________ Phone # ________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:________________________
________________________.

Name\Age________________________ Relationship________________________

QUESTIONNAIRE- PLANNING FOR VETERAN'S BENEFITS & MEDICAID-MARRIED

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:
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 and devices?
Yes □ No □
If yes, which digital assets: _____
To whom: _____

B. Last Will & Testament of Wife:

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___________________________
Address ______________________________ Phone # _________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:____________________
___________________________.

Name\Age______________________________ Relationship___________________________
Address ______________________________ Phone # _________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:____________________
___________________________.

Name\Age______________________________ Relationship___________________________
Address ______________________________ Phone # _________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:____________________
___________________________.

Name\Age______________________________ Relationship___________________________
Address ______________________________ Phone # _________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:____________________
___________________________.

Name\Age______________________________ Relationship___________________________
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 and devices?
Yes □ No □
If yes, which digital assets: _____
To whom: _____

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

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)

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

		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)

		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. 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 □

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

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)
		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

		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 Husband: 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:_____
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):_____

F. Designation of Health Care Surrogate for Wife: 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:_____
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):_____

G. Living Will for Husband: 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 to 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 Wife: 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 Husband (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? Yes ☐ No ☐
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: _____

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 Wife (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? Yes □ No □

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: _____

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*** (Husband):

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: _____
_____

L. ***DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS*** (Wife):

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/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: _____
_____

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: _____ Signature: _____
Print Name: _____ Print Name: _____
Date: _____ Date: _____