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

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

II. BACKGROUND INFORMATION

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

2. Marital Status: Widowed:______Divorced:______Separated: _______ Never married:________
   Name of former spouse: ______________________________
   If widowed provide date, county and state of spouse's death: _______________________________
   ______________________________. Date of Marriage:_________________

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

Included Deceased Children

Name/Age ________________________ ________________________
Relationship ________________________ ________________________
Address ________________________ ________________________
Phone # ________________________ ________________________
E-Mail: ________________________ ________________________
Adopted/Half-blood ____________________ ________________________

Name/Age ________________________ ________________________
Relationship ________________________ ________________________
Address ________________________ ________________________
Phone # ________________________ ________________________
E-Mail: ________________________ ________________________
Adopted/Half-blood ____________________ ________________________

Name/Age ________________________ ________________________
Relationship ________________________ ________________________
Address ________________________ ________________________
Phone # ________________________ ________________________
E-Mail: ________________________ ________________________
Adopted/Half-blood ____________________ ________________________

4. Grandchildren:

Name/Age ________________________ ________________________
Relationship ________________________ ________________________
Address ________________________ ________________________

Phone # ______________________ ______________________
Name of Parents ______________________ ______________________

Name/Age ______________________ ______________________
Relationship ______________________ ______________________
Address ______________________ ______________________
Phone # ______________________ ______________________
Name of Parents ______________________ ______________________

Name/Age ______________________ ______________________
Relationship ______________________ ______________________
Address ______________________ ______________________
Phone # ______________________ ______________________
Name of Parents ______________________ ______________________

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

Medicare/Private Insurance
Company: ______________________
Address: ______________________

Medicaid
Medicaid Program: ______________________
Medicaid ID & Case No.: ______________________

Other, Cancer, Accidental
Company: ______________________
Address: ______________________

Medicare Supplement
Company: ______________________
Address: ______________________

Long Term Care Insurance
Company: ______________________
Address: ______________________

Private Disability Insurance
Company: ______________________
Address: ______________________

IV. PERSONAL INFORMATION

1. Have you used your exemption from capital gains taxes on the sale of a residence within 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 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: ________ ____.

4. Are you on hospice? Yes ☐ No ☐ If yes, who is the provider?______________________
Name of contact person: ______________________________________

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.______________________________.

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

	YOU	**DECEASED SPOUSE**
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 - (5/7/75)	___________	___________
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 ☐

Do you currently receive any benefits? Yes ☐ No ☐ If yes, please explain:___________________________
____.

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: _____________ Last 4 digits of Account #:_____________________

Name of Owner:____

First Beneficiary: _________________________; Second Beneficiary: _______________________

Asset: ____

Name & Address of Co. ____

Value: _____________ Last 4 digits of Account #:___________________

Name of Owner:____

First Beneficiary: _________________________; Second Beneficiary: _______________________

Asset: ____

Name & Address of Co. ____

Value: _____________ Last 4 digits of Account #:___________________

Name of Owner:____

First Beneficiary: _________________________; Second Beneficiary: _______________________

Asset: ____

Name & Address of Co. ____

Value: _____________ Last 4 digits of Account #:___________________

Name of Owner:____

First Beneficiary: _________________________; Second Beneficiary: _______________________

Asset: ____

Name & Address of Co. ____

Value: _____________ Last 4 digits of Account #:___________________

Name of Owner:____

First Beneficiary: _________________________; Second Beneficiary: _______________________

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

Asset: ________________________________
Name & Address of Co. ________________________________
Value: ____________ Last 4 digits of Account #:____________
Name of Owner:________________________________
Taking minimum distribution Y-N: ______ Amount $________ Frequency________
First Beneficiary: ________________; Second Beneficiary: ________________

Asset: ________________________________
Name & Address of Co. ________________________________
Value: ____________ Last 4 digits of Account #:____________
Name of Owner:________________________________
Taking minimum distribution Y-N_____Amount $__________ Frequency _______
First Beneficiary: ________________; Second Beneficiary: ________________

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

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

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

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

7. Life Insurance:

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):

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

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PENSIONS. IF YOU RECEIVE A PENSION, BRING THE BOTTOM OF YOUR MOST RECENT CHECK.

Social Security $___________

VA Disability $___________ $______________

VA DIC $___________ $______________

Employment $___________

Pensions $___________
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: $___________

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 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:

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:______________________ 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:

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:______________
____.

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Name\Age__________________ Relationship______________Share_______________________
Address _________________________________ Phone # ____________________________
If beneficiary predeceases you, what should happen to this beneficiary's share:______________________
____.

Charity Name __________________________________ Share____________________________
Address ______________________________________ Phone #__________________________

Charity Name __________________________________ Share____________________________
Address ______________________________________ Phone #__________________________

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

4. . If you have minor children:

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

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

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

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

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

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

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

B. Durable Power of Attorney: If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship? Yes □ No □

1. Name/Relationship: ____

Address: ______________________________

2. Name/Relationship: ______________________________
Address: ______________________________

3. Indicate with a check mark (✓) whether you wish to give your agent the authority to handle the following matters:

Yes	No	Legal Authority
		Create and fund an inter vivos trust (i.e., revocable living trust)
		Make a gift (subject to restrictions)
		Create or change a beneficiary designation on life insurance
		Create or change a beneficiary designation on other assets
		Disclaim property to which you may be entitled (i.e. power of appointment; inheritance)

Yes	No	Legal Authority
		Amend, modify, revoke or terminate a trust (trust must give agent this authority also)
		Create or change rights of survivorship
		Waive your right to be a beneficiary of a joint and survivor annuity, including under a retirement plan
		Disclaim statutory rights (homestead; family allowance; elective share)

4. An agent is entitled to reimbursement of expenses reasonably incurred on your behalf. A qualified agent (spouse, heir, financial institution with trust powers, attorney, Certified Public Accountant) is entitled to reasonable compensation unless you decide otherwise.

Do you want your agent to be compensated? Yes □ No □
If yes, rate of compensation: ____________________

5. The Durable Power of Attorney is effective when signed. This means if your agent gets the original or a photocopy, he/she can begin making financial decisions for you immediately even if you are healthy and not incapacitated.

Do you want to keep the original Durable Power of Attorney? Yes □ No □
Do you want our law firm to hold the original document as your escrow agent? Yes □ No □

C. Designation of Health Care Surrogate: If you become unconscious or unable to communicate, do you want someone to make your medical decisions and thereby avoid a guardianship?

1. Name of Primary Surrogate/Relationship: ______________________________
Address: ______________________________
Home ________________ Office ________________ Cell ______________________

2. Name of Alternate Surrogate/Relationship: ______________________________
Address: ______________________________
Home: _________________ Office _________________ Cell ____________________

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

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

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

6. Name(s) of those persons, other than your surrogate, who you wish to send a copy of the executed document (i.e. your treating physician; family member):_______________________________

D. Living Will: If you are diagnosed with a terminal condition and your attending physician has determined that there can be no recovery from such condition and death is imminent do you want your life prolonged? Yes □ No □

1. In the event you can no longer chew food and swallow liquids orally, do you wish to receive food and water through artificial means such as a feeding tube surgically implanted in the stomach, an intravenous tube in the arm or, a nasogastric tube? Yes □ No □

2. Do you wish to receive medication for pain even if the amount of pain medication dulls your senses? Yes □ No □

3. Would you like to be cared for by Hospice. Hospice provides palliative care which includes feeding, dressing and bathing the person and administering pain medication. Hospice will not perform life sustaining measures such as CPR or restore breathing. Yes □ No □

4. If you also have a secondary illness (i.e. pneumonia, virus, cold) do you want the secondary illness treated (treating the secondary illness will not heal or correct the terminal illness)?
Yes □ No □

5. If you stopped breathing or your heart stopped beating would you want to be resuscitated?
Yes □ No □

6. Would you like to aid medical development in the fields of tissue and organ preservation, transplantation of tissues and tissue culture, reconstructive medicine and surgery and the development of medical research? If your body or organs are medically acceptable, upon your death do you wish to make an anatomical gift? Yes □ No □

If you answer "Yes" please complete the following:

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

E. Living Trust (a/k/a Revocable Trust)

1. Do you want to eliminate the need to probate your estate and have your assets distributed within a short time after your passing? Yes □ No □

2. Name & address of Trustee or Co-Trustees/Relationship:________________________________
____

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

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

Do you want your Trustee to be compensated?
If yes, rate of compensation__________________________________

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

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

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

Do you wish to authorize the Trustee to access any and all digital assets and devices?
Yes □ No □
If yes, which digital assets: ___________________________________

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

Do you wish to authorize the Trustee to access and distribute any and all digital assets and devices?
Yes □ No □
If yes, which digital assets: ___________________________________
To whom: ___________________________________

8. Disposition upon your death: ____
____

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

10. Credit shelter trust:____

F. ***DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS***

a. Would you like to designate in writing a trusted individual to make or, enforce arrangements for the disposition of your body at the time of your death? Yes □ No □
This individual would have authority to set the time and place of a service, communicate with a medical examiner, receive your remains or cremains as well as take steps to enforce any anatomical gift you

desire.

b. If yes, identify the primary authorized representative:
Name/Relationship:____
Address: ____

c. If yes, identify the successor authorized representative:
Name/Relationship:____
Address: ____

d. What is your preference for final arrangements? Burial _____ Cremation ______
e. Detail any special wishes for your final arrangements, memorial service, etc. _____________________
____
f. Detail any restrictions you want to place on the representative's authority: ________________________
____

G. Do you have any professional advisors who you wish us to work with? Please provide us with their names, addresses and telephone number. If you are not currently working with any of the following professionals, would you like our office to provide you with a recommendation? Yes ☐ No ☐
Accountant:____
Financial Planner:____
Insurance Advisor: ____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature: _______________________________
Print Name: ______________________________
Date: ___________________________________

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