STEPHANIE L. SCHNEIDER, P.A.
PLANNING QUESTIONNAIRE FOR YOUNG ADULTS

INSTRUCTIONS:
PLEASE COMPLETE THE QUESTIONNAIRE COMPLETELY TO THE BEST OF YOUR ABILITY. YOUR ACCURACY AND COMPLETENESS IN THE RESPONDING WILL HELP US TO BEST ADVISE AND REPRESENT YOU. YOU MAY CALL OUR OFFICE FOR ASSISTANCE.

I. GENERAL INFORMATION

1. Were you referred to our office and if so, by whom? ______________________________.

II. BACKGROUND AND FAMILY INFORMATION

1. Name:____
D.O.B.:___________ SS#__________________
Phone Number(s):(H) _________________ (C)_________________ (O)__________________
E-mail_______________________________
Current Address:____

2. List names of your living siblings.

Name\Age ________________________ ________________________________
Relationship ________________________ ________________________________
Address ________________________ ________________________________
Phone # ________________________ ________________________________

Name\Age ________________________ ________________________________
Relationship ________________________ ________________________________
Address ________________________ ________________________________
Phone # ________________________ ________________________________

3. List names of living parents:

Name\Age ________________________ ________________________________
Relationship ________________________ ________________________________
Address ________________________ ________________________________
Phone # ________________________ ________________________________

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

Private Insurance
Company: ___________________________
Address: ____________________________

IV. PERSONAL INFORMATION

1. Are you at risk because of a medical condition or family history of becoming seriously ill or disabled or, are you presently experiencing an illness? __ If yes please explain: ________________________________
____.

5. Do you have a diagnosis of a mental health condition and if so, please identify it.__________________
____.

V. ASSETS

1. Real Estate located in Florida:

Address: ____
FMV: ____
(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: ____
FMV: ____
(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:

Type	Year	FMV	Liens	Owner

4. Stocks, securities, bonds, and investments:

Asset: ____
Name & Address of Co. ____
Value: _____________ Account #:___________________________
How is it titled:____
When does it come due and interest rate: ___________________________________

Asset: ____
Name & Address of Co. ____
Value: _____________ Account #:___________________________
How is it titled:____
When does it come due and interest rate: ___________________________________

5. Retirement and pension plans (include IRAs and 401Ks):

Asset: ____
Name & Address of Co. ____

Value: _____________ Account #:___________________________
How is it titled:____
Taking minimum distribution Y-N:_____ Amount $________ Frequency_________

Asset: ____
Name & Address of Co. ____
Value: _____________ Account #:___________________________
Taking minimum distribution Y-N:__________Amount $_________ Frequency_________

6. Bank Accounts:

Asset: ____
Name & Address of Co. ____
Value: ______________ Account #:____________________________
How is it titled:____
When does it come due and interest rate: ____________________________________

Asset: ____
Name & Address of Co. ____
Value: ______________ Account #:_____________________________
How is it titled:____
When does it come due and interest rate: _____________________________________

7. Life insurance:

Name of Owner ___________________________ ______________________________________
Name of Insured __________________________ ______________________________________
Name of Insurer __________________________ ______________________________________
Policy #:_______________________________________ _______________________________
Face Value:____
Cash Surrender Value:____
Term or whole life: ________________________ ______________________________________
Beneficiary (ies):____

A. Durable Power of Attorney:

If you become incapacitated, do you want someone to make your financial decisions and thereby avoid a court supervised guardianship?

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)

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

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

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

Do you want your agent to be compensated? _____ Yes _____ No

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

B. 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:______________________________

Address:____

Telephone: Office _________________ Home _______________

Relationship: ____

2. Name of Alternate Surrogate:______________________________

Address:____

Telephone: Office _________________ Home _______________

Relationship: ____

3. 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):______________________________

C. 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 ______only the following organs or parts:

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

____

for the purpose of transplantation, therapy, medical research, or education;

b) ________________ my body for anatomical study if needed. Limitations or special wishes, if any, are as follows: ____

____

D. ***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 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 restrictions you want to place on the representative's authority: ______________________

____

____

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

____

Print Name: ______________________________

Date: ______________________________