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* Certified as an Elder Law Attorney by the National Elder Law Foundation.
Neither the Supreme Court of Missouri nor the Missouri Bar reviews or approves
certifying organizations or specialist designations.

PLANNING QUESTIONNAIRE

This form is extremely important to us! Accurately completing this about the person(s) for whom we are planning will help us to answer your questions & to understand the needs we are to address. **Please use back side of pages or additional sheets of paper if you need more room.**

PLEASE PRINT

I. PERSONAL IDENTIFYING INFORMATION

Client

Spouse (If applicable)

Full Name(s): _____

Address(es): _____

(Enter if address is different than yours)

City, County, State, Zip: _____

Mailing Address (if different) _____

Social Security Number(s): _____

Telephone Numbers: (_____) _____
Home

(_____) _____
Home-Enter spouse's home number only if different than yours

(_____) _____
Work

(_____) _____
Work

(_____) _____
Cell

(_____) _____
Cell

Birth Date: _____

Birth Date: _____

Birth Place: _____

Birth Place: _____

If employed or retired, what is/was the occupation and who is/was the employer:

Yourself

Spouse

Were there any prior marriages? If yes,

Were you previously married? Yes ___ No ___ If yes, how many times? _____

Spouse previously married? Yes ___ No ___ If yes, how many times? _____

For each prior marriage of either spouse, indicate on a separate sheet of paper or on the reverse:

Name of prior spouse _____

Date of marriage _____

Date of termination of marriage _____

Reason for termination (death, divorce) _____

Whether prior spouse is still living _____

How many children born or adopted during that marriage _____

(Please be prepared to supply copies of divorce decrees to the attorney, if requested.)

Do you have a Pre or Post-Nuptial Agreement? Yes___ No_____ (If yes, please provide a copy to the attorney.)

Please print your names EXACTLY how you sign them on formal documents (such as spelling out your middle name or using an initial. This is how we will have you sign any documents that we prepare for you This should be the same as how your name appears on your Social Security Card):

Yourself _____ Spouse _____

Do you belong to a church or religion? Yes; No. If yes for either or both, what church or religion is it?

Yourself _____ Spouse _____

Who is your pastor/priest/rabbi?

Yourself _____ Spouse _____

II. FAMILY INFORMATION

Enter your parents' names and ages if living (or ages at death if deceased):

YOURSELF: Mother _____ Father _____

Age _____; Living or deceased? _____ Age _____; Living or deceased? _____

SPOUSE: Mother _____ Father _____

Age _____; Living or deceased? _____ Age _____; Living or deceased? _____

Do you want to make arrangements in your will, trust, or other document for the care of a pet? Yes, No
If yes, what is the name of and any special instructions for your pet? _____

ON THE NEXT PAGE, PLEASE ENTER NAMES, ADDRESSES, AND PHONE NUMBERS OF CHILDREN AND THE RESPECTIVE PARENT OF EACH (IF NOT CHILDREN OF BOTH AND INCLUDE STEPCHILDREN IF NOT THE CHILDREN OF BOTH BECAUSE NECESSARY TO REFERENCE IN PLAN) Please use extra paper if you need more space:

<u>Full name of each natural or adopted child/stepchild with parent indicated (if not child of both) & child's occupation</u>	DOB	If married, enter spouse's name	Name of grandchild(ren)	Address & home phone number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Please provide your brothers' and sisters' full name(s), the city and state where they live, and the number of children each has (please list on back if you need more space):

Name(s)	City/State/Zip	No. of Children
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide your spouse's brothers' and sisters' full names, the city and state where they live, and the number of children they have:

Name(s)	City/State/Zip	No. of Children
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other close friends or relatives such as nieces and nephews if they are helping you with your affairs or live with you:

III. HEALTH INFORMATION

Please identify your current primary physician(s); city where located, and fax number (please use back of page to name other specialists):

Yourself	Spouse
_____	_____
_____	_____
_____	_____

Please provide health status information such as diagnoses and conditions:

Yourself

Spouse

What medications are presently being taken?

Yourself

Spouse

If assistance is needed with any activities (instrumentalities) of daily living please check:

Yourself

Spouse

Eating/Drinking

Ambulating

Transferring

Toileting

Bathing/Personal Hygiene

Continence

Taking Medications

Supervision to Keep From Wandering

If there is a problem with the capacity to make decisions, such as with dementia or Alzheimer's, please explain:

Yourself: _____

Spouse: _____

If the client or spouse is in an assisted living facility, residential care facility, or nursing home, give facility's name and address.

Yourself: _____

Spouse: _____

What was the date each person entered the facility? _____

What is the person's daily nursing home charge? \$ _____ Prescription drugs costs \$ _____

Over the counter or non-prescription medications? \$ _____ Beautician/barber? \$ _____ Other

health information: _____

IV. CURRENT ESTATE PLANNING/DOCUMENTS

Please bring copies o any documents you already have to our office for review during your appointment.

Do you have a will? Yes___ No___ Does your spouse have a will? Yes___ No___

Do you have a Living Will? Yes___ No___ Does your spouse have a Living Will? Yes___ No___

Do you or your spouse have Healthcare Directives/Durable Powers of Attorney for Healthcare?
Yourself: Yes___ No___ If yes, who is the agent(s)? _____
Spouse: Yes___ No___ If yes, who is the agent(s)? _____

Do you or your spouse have Financial Powers of Attorney?
Yourself: Yes___ No___ If yes, who is the agent(s)? _____
Spouse: Yes___ No___ If yes, who is the agent(s)? _____

Do you or your spouse have a Trust?
Yourself: Yes___ No___ If so, the title/date is _____
Spouse: Yes___ No___ If so, the title/date is _____

Are you or your spouse the beneficiary of someone else’s Trust? Yes___ No___
If so, please give details: _____

Have you made your funeral or burial arrangements?
Yourself: Yes___ Please list funeral home and cemetery: _____
No___ What are your wishes: burial or cremation? where? which funeral home? _____
Spouse: Yes___ Please list funeral home and cemetery: _____
No___ What are your wishes: burial or cremation? where? which funeral home? _____

Whom do you or your spouse want to make your funeral and cremation or burial arrangements?
Yourself _____ Spouse: _____

Do you or your spouse want to make anatomical gifts of organs or tissue?
Yourself: Yes___ No___ Any limitations? _____
Spouse: Yes___ No___ Any limitations? _____

Do you or your spouse want your agent in a durable power of attorney to consent to an autopsy for you, if indicated?
Yourself: Yes___ No___ Spouse: Yes___ No___

Are you or your spouse a Veteran? _____ If so, what benefits do you receive? _____

Do you or your spouse have Long Term Care Insurance? If yes, please answer the following:

	Yourself	Spouse
1. Insurance company name:	_____	_____
2. Number of months of coverage	_____	_____
3. How much does it pay per day?	_____	_____
4. Does it pay for in-home care?	_____	_____
5. How much is the monthly premium?	_____	_____

Do you or your spouse have Medicare Supplement/Medigap Insurance, Medicare Advantage, or Health Insurance?

Yourself: Yes___ No___ If yes, please complete the following:

Company Name _____ Monthly Premium \$ _____

Who is paying the premium _____ Enter plan type (A -J) _____

Spouse: Yes___ No___ If yes, please complete the following:

Company Name _____ Monthly Premium \$ _____

Who is paying the premium _____ Enter Plan type (A -J) _____

Do you or your spouse have Medicare Part D Prescription Drug Benefits or “creditable coverage”?

Yourself: Yes___ No___ If yes, please complete the following:

Company Name _____ Monthly Premium \$ _____

Spouse: Yes___ No___ If yes, please complete the following:

Company Name _____ Monthly Premium \$ _____

Have either of you now ever received MO HealthNet (i.e., Medicaid), or similar benefits to pay for medical services in this or any other state? Yes ___ No ____ . If so, what is your Department Client (or MO HealthNet Number)?

V. ASSETS/DEBT

Savings Bond Series	Issue Date	Face Value \$	Owner's Name
Total		\$	

Bank/Credit Union Accounts	Name of Bank or Credit Union	Balance \$	Owner/Names on the Accounts (Include if POD)
Checking			
Checking			
Checking			
Checking			

Bank/Credit Union Accounts	Name of Bank or Credit Union	Balance \$	Owner/Names on the Accounts (Include if POD)
Savings			
Savings			
Money Market			
Money Market			
Certificate of Deposit			
Certificate of Deposit			
Certificate of Deposit			
Certificate of Deposit			
Certificate of Deposit			
Certificate of Deposit			
Certificate of Deposit			
Total		\$	

Stocks & Bonds	Corporation/Company Name or Brokerage Name	Value \$	Enter Owner or Names on the Accounts (Include if TOD)
Stocks			
Stocks			
Stocks			
Bonds			
Bonds			
Total		\$	

Business Name	Type	Ownership Interest	Value \$

Retirement Plan Types	Name of Company or Financial Institution(s)	Value \$	Name of Owner and Beneficiary(s)
IRA			Owner: Beneficiary(ies):
IRA			Owner: Beneficiary(ies):
IRA			Owner: Beneficiary(ies):
IRA (Roth)			Owner: Beneficiary(ies):
IRA (Roth)			Owner: Beneficiary(ies):
401K Plan			Owner: Beneficiary(ies):
Deferred Comp.			Owner: Beneficiary(ies):
Deferred Comp.			Owner: Beneficiary(ies):
Annuity			Annuitant: Beneficiary(ies):
Annuity			Annuitant: Beneficiary(ies):
Annuity			Annuitant: Beneficiary(ies):
Total		\$	

LIFE INSURANCE, Enter Name of Company/Cash Value	Face Value \$	Names of Insured, Owner, & Beneficiary
		Insured: Owner: Beneficiary(ies):
		Insured: Owner: Beneficiary(ies):

LIFE INSURANCE, Enter Name of Company/Cash Value	Face Value \$	Names of Insured, Owner, & Beneficiary
		Insured: Owner: Beneficiary(ies):
		Insured: Owner: Beneficiary(ies)
		Insured: Owner: Beneficiary(ies):
Total Face Value of Life Insurance	\$	

Promissory Notes, Accounts Receivable & Other Funds Owed to You or Your Spouse. Explain Nature of Debt (for example, personal loan or promissory Note secured by Deed of Trust)	Amount Owed to You &/or Your Spouse \$	Borrower's Name(s)
Total Value of Debt Owed to You	\$	

Real Estate: give county, location, & property type (e.g., house on 1/3 acre at 135 Forest Hill Ave, Jefferson City, Cole County, MO 65109) Need copies of deeds.	How is it being used? (Home, 2nd home, rental, vacant, etc.)	Value \$	How is it titled? Whose name(s) are on the property?

Titled vehicles—autos, trucks, motorcycles, boats, motors, trailers. Enter make, model, and year	How being used?	Value \$	How titled? Whose name(s) is on the property?
Enter total value of titled vehicles		\$	

Debts: Enter Creditor and type (for example, mortgage on home, vehicle loan, credit card, personal loan)	How much owed? \$	Enter name(s) of person who owes the money.
<u>Total Amount of Debt Owed</u>	\$	

Tangible Personal Property	Value for Yourself \$	Value for Spouse \$	Jointly Owned Value \$
Clothing			
Jewelry			
Antiques			
Household Furnishings			
Collectibles			
Other, including guns; farm machinery, equipment, and implements; cattle and livestock; :			
_____	\$ _____	\$ _____	\$ _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Total Personal Property	\$ _____	\$ _____	\$ _____

Please note any comments or additional information about assets & resources(for example, furniture is in storage):

VI. INCOME

Type of Income	Yourself \$	Spouse \$
Salary		
Social Security		
Retirement Pension		
IRA, Deferred Comp, 401(k), etc.		

Type of Income	Yourself \$	Spouse \$
Rent		
Interest		
<u>Dividends</u>		
<u>Civil Service</u>		
<u>Veteran's Benefit</u>		
<u>Farm or Business Income</u>		
<u>Other</u>		
<u>Other</u>		
<u>Total monthly income for each</u>	\$	\$
<u>Total for both:</u>	\$	

Do you or your spouse have a safe deposit box? If yes, identify location(s) & contents: _____

VII. GIFTS AND CHARITABLE CONTRIBUTIONS

In the last five years, have you or your spouse transferred or given away any assets such as property or money with a value of \$100 or more (including charitable contributions and church tithing)? Yes _____ No _____
 If so please explain what was given, whether gift tax returns were filed, dates if transfers, and reasons below.
 Do you tithe through your church? _____ If so how much do you give a year? \$ _____

VIII. FIDUCIARIES (i.e., Who will make decisions or manage your estate when you can't)

When we prepare documents, a **fiduciary** is someone whom you entrust to take care of your when you are incapacitated or your assets if you are disabled or deceased. These fiduciaries might be an institutional trustee, such as a Bank Trust Department, or an individual, such as an adult child or a sibling. They will have very important specific duties and responsibilities as set out in state law for each type of document, such as a personal representative of a will and your agent designated in a health care durable power of attorney to make your medical decisions.

Please choose qualified persons whom you trust to serve who will follow your instructions, preferences, and wishes. For example, someone who works in a bank or is an accountant might be good to assist you with managing your finances and your property while someone who is working in the health care field might be good to serve as your agent under your durable power of attorney for healthcare.

Please indicate your choices below and be prepared to discuss your choices with your attorney.

1. Trustees for Trusts

If you plan to have a trust, please give the desired trustee's name and relationship:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

If spouse plans to have a separate trust, please give desired trustee's name and relationship to your spouse:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

NAME OF TRUST: If you plan to have a trust, what would you want to name it?

(EXAMPLE: "Smith Trust" or "Smith Family Trust," or "Tom and Myrtle Smith Revocable Trust"?)

2. Personal Representatives for Wills

If you plan to have a will, please indicate the person's name and relationship to serve as a personal representative:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

If your spouse plans to have a will, please indicate the person's name and relationship to serve as your spouse's personal representative:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

3. Agents Under Financial Durable Powers of Attorney

If you plan to have a financial power of attorney, please give agent's name and relationship:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

If your spouse plans to have a financial power of attorney, please give agent's name and relationship to your spouse:

<u>Name</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____

4. Agents Under Healthcare Durable Powers of Attorney and Healthcare Directives

Yourself

Spouse

1st Agent: _____
Name

Address

City, State Zip

Telephone No(s)

Name

Address

City, State Zip

Telephone No(s)

2nd Agent: _____
Name

Address

City, State Zip

Telephone No(s)

Name

Address

City, State Zip

Telephone No(s)

3rd Agent: _____
Name

Address

City, State Zip

Telephone No(s)

Name

Address

City, State Zip

Telephone No(s)

5. Guardian/Conservator of Minor Children

If you have minor children, whom would you want to be their Guardian/Conservator if you died?

1st Choice

2nd Choice

Name

Name

Address

Address

City, State Zip

City, State Zip

Telephone No(s)

Telephone No(s)

IX. HIPAA AUTHORIZATION TO RELEASE MEDICAL INFORMATION

“HIPAA” stands for “Health Insurance Portability and Accountability Act,” a law that passed in 1996 with regulations issued in 2003 requiring certain safeguards to protect confidential medical information. If you want members of your family, friends, trustees, and others to find out about how you are doing in the hospital or nursing home, then you need to authorize the hospital, nursing home, and staff to release information to them. Also, if you want the physician, nurse, counselor, or other healthcare provider to discuss your medical status with someone else, you need to authorize that person to be able to talk to your healthcare provider. This person need not be your decision maker (i.e., agent under your healthcare durable power of attorney). It might be a good idea to authorize only a few people of a very big family and have those few keep the others informed because of the excess time that it would take for staff to talk with every family member when too many call.

Please indicate below the persons who should be authorized to receive medical information from your healthcare providers about status, diagnosis, and prognosis:

Yourself

Name & Relationship to you

Spouse

Name & Relationship to spouse

