



New York's Elder Law Team

CONFIDENTIAL: This questionnaire is designed to help us gather information necessary so that we may properly plan for you, will be held in strict confidence, and will be reviewed during our meeting. You may ignore the questions that do not apply to you. Whether you are a new or an existing client, this questionnaire is extremely helpful, and we ask that you **complete it fully**. Please feel free to attach additional pages where space is insufficient or to provide other information you feel is relevant.

ELDER LAW / ESTATE PLANNING QUESTIONNAIRE

Person Completing Form: _____ Relationship to Client: _____

**The client is the person implementing the planning.*

**Additional Space for Non-Client information can be found on the next page.*

A. PERSONAL INFORMATION

Client 1:

Client Legal Name (as it appears on Government Issued ID): _____

A/K/A (if any): _____

Date of Birth: _____

Mailing Address: _____

Home Address: _____

Sex: Male Female

U.S. Citizen?: Yes No

Veteran?: Yes No

Occupation: _____

Telephone Numbers:

Cell: _____

Home/Work: _____

E-Mail Address: _____

I authorize communication with me via E-Mail.

Client 2:

Client Legal Name (as it appears on Government Issued ID): _____

A/K/A (if any): _____

Date of Birth: _____

Mailing Address: _____

Home Address: _____

Sex: Male Female

U.S. Citizen?: Yes No

Veteran?: Yes No

Occupation: _____

Telephone Numbers:

Cell: _____

Home/Work: _____

E-Mail Address: _____

I authorize communication with me via E-Mail.

IMPORTANT NOTICE: Please use a personal e-mail address rather than a work e-mail address, as no attorney-client privilege extends to communications transmitted through your employer e-mail address.

What are your goals for your meeting?: _____

Please select how you would like correspondence and any drafts/documents to be sent to you:

Both hard copies & electronic copies Hard copies only Electronic copies only

Marital Status:

Single Married Domestic Partnership Widowed Divorced Separated

Date of Marriage or Civil Union (if divorced, please state name of ex-spouse and provide date of divorce):

Please provide information regarding previous marriages or civil unions, if any:

Please list any medical conditions and the approximate date of diagnosis:

B. OTHER INTERESTED PARTY/ DECEASED PARTY

Name: _____ Date of Birth/Death: _____

Relationship to Client(s): _____

Address: _____

Telephone Numbers: Preferred: _____ Alternate: _____

E-Mail Address: _____

C. GENERAL INFORMATION

Who is the consultation for (check all that apply):

Self Spouse Other: _____

What is this consultation regarding (check all that apply):

Estate Planning Medicaid Guardianship Elder Law Planning Other: _____

How did you hear about us?: _____

D. CHILDREN AND GRANDCHILDREN

Please list all children (living and deceased). Put a “D” next to any predeceased child’s name. Please indicate whether any deceased child left any surviving children (grandchildren).

Children

Full Name (as it appears on Government Issued ID)	Address (if different from client’s)	Date of Birth	Spouse’s Name (if married)

Grandchildren

Full Name (as it appears on Government Issued ID)	Address (if different from client’s)	Date of Birth	Spouse’s Name (if married)

Do any of your children and/or grandchildren have special needs or do you have any concerns regarding your children and/or grandchildren (e.g., substance abuse, creditors, medical conditions, disabilities, divorce concerns, etc.)? If yes, please explain: _____

E. OTHER AGENTS/BENEFICIARIES

If you plan to appoint or provide for individuals other than your children/grandchildren, please list them here:

Full Name (as it appears on Government Issued ID)	Address (if different from client’s)	Date of Birth	Spouse’s Name (if married)

Do any of the aforementioned individuals have special needs or do you have any concerns regarding the aforementioned individuals (e.g., substance abuse, creditors, medical conditions, disabilities, divorce concerns, etc.)? If yes, please explain: _____

F. HEALTHCARE INFORMATION

Do you have Medicare? Yes No

Do you have Long Term Care Insurance? Yes No

If yes: Please bring or send us a copy of the policy statement showing the daily rate and policy limit.

Do you receive Medicaid Benefits? Yes No

If yes:

Home Care Medicaid? Yes No

Nursing Home Medicaid? Yes No

Do you receive Veterans Benefits? Yes No

G. DOCUMENTS

Do you have a Will? Yes No Date: _____

Do you have a Power of Attorney? Yes No Date: _____

Do you have a Health Care Proxy? Yes No Date: _____

Do you have a Living Will? Yes No Date: _____

Do you have a Trust? Yes No Date: _____

If yes: Is it revocable or irrevocable? _____

Do you have a Pre/Postnuptial Agreement? Yes No Date: _____

**If you have any of the above documents, please bring them to our meeting.*

H. GIFTS YOU HAVE MADE

(\$2,000 or more in the last 5 years, or more than \$10,000 during your lifetime)

Donor	Donee	Date Given	Was a Gift Tax Return Filed?	Amount Gifted
				\$
				\$
				\$

I. INCOME (Please list monthly amounts)

Income Type	Client 1	Client 2 / Spouse	Total
Salary			\$
Annuities			\$
Social Security			\$
Interest			\$
Dividends			\$
Pension			\$
IRA/401K RMD			\$
Rental Income			\$
Other Taxable Income			\$
			\$
Other Non-Taxable Income			\$
			\$

J. ASSETS AND LIABILITIES

1. Real Estate

Type of Real Estate (Real Property, Co-op, Land, etc.)	Title/Owner	Address	Estimated Fair Market Value	Mortgage Balance	Purchase Price
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

4. Retirement Accounts and/or Benefits

Owner(s)	Type of Account (403B/401k/IRA/Keogh)	Traditional or Roth	Beneficiary	Approximate Balance
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$

5. Life Insurance

Owner(s)	Insured	Company	Face Amount	Type of Policy and Cash Value (if whole life)	Beneficiary
			\$		
			\$		
			\$		
			\$		
			\$		
			\$		

6. Business and Professional Interests:

Please provide details for ownership interests in any partnership, joint venture, sole proprietorship, LLC, closely held corporation or other business entity.

Owner(s) and % of Ownership	Company or Entity Name	Type of Entity	Company Value
			\$
			\$
			\$
			\$
			\$
			\$

7. Tangible Personal Property of Significant Value

Please provide information for other significant assets you own, either jointly or separately, including items such as boats, automobiles, jewelry, art collections, or any other personal property valued at \$50,000 or more, or any collection valued at \$50,000 or more.

Type of Property	Owner	Approximate Value
		\$
		\$
		\$
		\$

K. INFORMATION REGARDING OTHER PROFESSIONALS:

Accountant

Name: _____

Firm: _____

Phone Number: _____

E-Mail Address: _____

Financial Advisor

Name: _____

Firm: _____

Phone Number: _____

E-Mail Address: _____