



ATLAS LAW GROUP

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ELDER LAW/ESTATE PLANNING QUESTIONNAIRE

Please complete the following questionnaire to the best of your ability. This information provides us with the necessary information so that we may properly plan for you. This information will be held in the strictest confidence. Do not be upset if you cannot complete all of the questions.

PERSONAL INFORMATION:

Name: _____
Last First M.I. Date of Birth: _____ Social Security Number: _____

Address: _____
Street Town State & Zip Code

Telephone: Home: _____ Business: _____
Fax: _____ Fax: _____
Cell: _____ Email: _____

Military Service: _____ **Citizenship:** _____

HEALTH STATUS: _____

MARITAL INFORMATION:

If spouse predeceased, please state date of spouse's death: _____

CLIENT OBJECTIVE(S): _____

NOTE: Please bring the following documents to our meeting, if available/applicable: (a) Last Will and Testament), (b) Power of Attorney, (c) deed to residence and real properties, (d) last two years tax returns, (e) life and health insurance policies and (f) any other documents or information you deem relevant.

CONTACT PERSON: _____ **Relationship:** _____

Name	Address	Phone #	Age	Parents' names

(If additional grandchildren, please use the back of this sheet)

Please list names and relationships of persons who may be dependent on you for support or who may affect your planning.

GENERAL INFORMATION:

Do you receive Social Security?..... () Yes () No
 If so, where is the check deposited? _____

Have you been appointed as a fiduciary (executor, trustee, attorney-in-fact, etc.) under any legal documents?..... () Yes () No
 If so, please describe said documents: _____

Are you involved in a lawsuit?..... () Yes () No
 If so, please explain: _____

Do any family members require special attention?..... () Yes () No
 If so, please explain (For example, health, physical, mental, financial status, special and/or individual needs? (Use another sheet if necessary)

Does anyone in your family receive Social Security Disability? () Yes () No

GENERAL INFORMATION CONTINUED:

Does anyone in your family receive Supplemental Security Income? () Yes () No

Is anyone at risk because of becoming seriously ill or disabled (due to a medical condition or family history)? () Yes () No

If so, please explain:

If you were unable to make health care decisions for yourself, who would you want to make those decisions for you?(list in order):

1. _____
2. _____
3. _____
4. _____

If you were unable to make financial decisions, who would you want to pay bills, make investment decisions and carry out other financial transactions for you (list in order):

1. _____
2. _____
3. _____
4. _____

HEALTH CARE INFORMATION:

Do you have or receive the following? () Yes () No
Medicare Part A _____ Part B _____ Part C _____ Part D _____

Supplemental Insurance..... () Yes () No
If yes, name: _____

Medicare HMO?..... () Yes () No
If yes, name: _____

Long Term Care insurance..... () Yes () No
If yes, name: _____

Medicaid Benefits?..... () Yes () No

Veterans Benefits?..... () Yes () No

LEGAL DOCUMENTS:

Please indicate if you have any of the following:

Last Will and Testament..... () Yes () No
Date of Will(s): _____

Durable Power of Attorney..... () Yes () No

Health Care Proxy..... () Yes () No

Health Care Declaration (also known as a Living Will) () Yes () No

Living Trust..... () Yes () No
Irrevocable or Revocable?

BURIAL ARRANGEMENTS:

Do you own a burial plot?..... () Yes () No
If so, where is it located?: _____

Irrevocable Burial Fund Contract?..... () Yes () No
(If yes, please provide a copy)

PROFESSIONAL ADVISORS:

Tax Preparer/Accountant: Name: _____ Company: _____

Address: _____
Street Town State & Zip Code

Telephone: _____ Fax _____ Email: _____

Investment Advisor: Name: _____ Company: _____

Address: _____
Street Town State & Zip Code

Telephone: _____ Fax _____ Email: _____

Insurance Agent: Name: _____ Company: _____

Address: _____
Street Town State & Zip Code

Telephone: _____ Fax _____ Email: _____

Person who referred you to our office:

Is this person a client of our firm?

Name: _____

()Yes ()No

Title: _____ Company: _____

Address: _____
Street Town State & Zip Code

Telephone: Home: _____ Business: _____

Fax: _____ Email: _____

MONTHLY INCOME: Please list your estimated monthly income and health care expenses.

<u>Income Type</u>	<u>Gross Income</u>	<u>Deductions</u>	<u>Total</u>
Social Security	_____	_____	_____
Interest	_____	_____	_____
Dividends	_____	_____	_____
Pension Benefits	_____	_____	_____
IRA Benefits	_____	_____	_____
Rental Income	_____	_____	_____
Capital Gains (Losses)	_____	_____	_____
Other Taxable Income	_____	_____	_____
Other Non-Taxable Income	_____	_____	_____
Total Income	_____	_____	_____

MONTHLY HEALTH CARE EXPENSES

Total

Home Care _____

Insurance Premiums _____

Prescription drugs _____

Nursing Home _____

Other _____

~~Total Expenses~~

ASSETS

Real Estate

<u>Owner</u>	<u>Location</u>	<u>Estimate Value</u>	<u>Mortgage Balance</u>	<u>Cost Basis</u>
_____	(a) _____	_____	_____	_____
_____	(b) _____	_____	_____	_____
_____	(c) _____	_____	_____	_____
_____	(d) _____	_____	_____	_____

Do you receive a veteran's exemption on your primary residence? ()Yes ()No

Do you receive a senior citizen's exemption on your primary residence? ()Yes ()No
How much do you pay each year in real estate taxes? _____

Do you believe your property is over assessed?..... ()Yes ()No

If you receive rental income, please describe: _____

Cash, Bank Accounts and Certificates of Deposit

<u>Owner</u>	<u>Name of Financial Institution</u>	<u>Amount</u>
Checking Accounts		
_____	_____	\$ _____
_____	_____	\$ _____

Savings/Money Market Accounts		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Certificates of Deposit		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Stocks and Bonds (Individually held)		
	Name of stock and number of shares	
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Brokerage Accounts		
	Name of Financial Institution	
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Mutual Funds	Name of Financial Institution	
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Savings Bonds	Type	
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Life Insurance

<u>Owner</u>	<u>Company</u>	<u>Face Amount</u>	<u>Cash Value</u>	<u>Insured</u>	<u>Beneficiary</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Retirement Benefits

<u>Owner</u>	<u>Description</u>	<u>Beneficiary</u>	<u>Principal Value</u>
401(K) Plan/Keogh/403(B)			
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

IRA Accounts

_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Annuities, Mortgages and Notes (money owed to you)

<u>Owner Value</u>	<u>Description</u>	<u>Beneficiary</u>	<u>Purchase Price</u>
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Tangible Personal Property

Home Furnishings

<u>Owner</u>	<u>Location</u>	<u>Value</u>
_____	_____	\$ _____
_____	_____	\$ _____

Automobiles

_____	_____	\$ _____
_____	_____	\$ _____

Jewels and/or Furs

_____	_____	\$ _____
_____	_____	\$ _____

Other (Collections, etc.)

_____	_____	\$ _____
_____	_____	\$ _____

Safe Deposit Boxes () Yes () No

Is there a deputy on the box? () Yes () No

<u>Owner</u>	<u>Location of Box</u>	<u>Contents</u>	<u>Location of Key</u>	<u>Estimated Value</u>
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

Business Interest(s) (i.e., partnership, corporate interests or sole proprietorships).

Miscellaneous

GIFTS

Include gifts made in the last five (5) years that are over \$2,000.

Donor	Donee	Date Given	Value

LIABILITIES: (Debt owed by you or your spouse, contractual and leasehold obligations, pending lawsuits and claims, etc.)

<u>Description</u>	<u>Name of Debtor</u>	<u>Amount</u>	<u>When Due</u>
General Debts			
Notes and accounts payable by you	_____	_____	_____
Loans on life insurance policies	_____	_____	_____
Unsecured promissory notes	_____	_____	_____
General obligations	_____	_____	_____
Other	_____	_____	_____
Mortgage Payables			
Home Mortgages	_____	_____	_____
Other Mortgages	_____	_____	_____
Total Liabilities	_____	_____	_____

SUMMARY OF ASSETS AND LIABILITIES

ASSETS	Individual Name	Joint Name	Total
1. Real Estate			
2. Cash			
3. Checking			
4. Savings/Money Market			
5. Certificates of Deposit			
6. Stocks and bonds			
Individually held			
Brokerage			
Mutual Funds			
Savings Bonds			
7. Life Insurance (face value)			
8. Retirement Benefits			
401(K)			
IRA Accounts			
9. Annuities, Mortgages and Notes			
10. Personal Property			
11. Business Interests			
Total Assets			
LIABILITIES	Joint Name	Husband's Name	Total
1. Debt			
2. Mortgage Payables			
Total Liabilities			
NET WORTH			