TIMOTHY RICE
Estate and Elder Law Firm

ESTATE & MEDICAID PLANNING QUESTIONNAIRE

[PLEASE PRINT LEGIBLY) **Answer those questions which are applicable to your situation ONLY.**

Today's Date: _____ **Referred by:** _____

Referral Type: ☐ Internet Search ☐ Advertisement ☐ Bar Association ☐ Social Media ☐ Other: _____

_____ _____
Referral Email Address

_____ _____
Telephone No. City, State, Zip

NOTE: If you are completing this form for a parent, family member or friend, please provide your information below:

_____ _____
Name of Party completing form Address

_____ _____
Telephone No. City, State, Zip

_____ _____
Email Relation to Client

☐ **Check here if you wish all correspondence and billing to this contact/address.** (Note: If you do not check this box, all correspondence and/or billing will be directed to the client at the address low.

CLIENT:

_____
First MI Last

_____
A/K/A (If applicable) SSN DOB

_____
Address

_____
City State Zip

_____
Phone No(s). [ ] mobile [ ] home [ ] work

Email Address: _____

_____
Employer Name & Address

_____
Occupation

SPOUSE/ CIVIL UNION/ DOMESTIC PARTNER:

First | MI | Last

A/K/A (If applicable) | SSN | DOB

Address

City | State | Zip

Phone No(s). [ ] mobile | [ ] home | [ ] work

Email Address: _____

Employer Name & Address

Occupation

PETS (*IF applicable)*

PET #1

Name | Species | DOB/ Age

Proposed Caregiver | Email | Phone Number

Proposed Trustee | Email | Phone Number

PET #2

Name | Species | DOB/ Age

Proposed Caregiver | Email | Phone Number

Proposed Trustee | Email | Phone Number

PET #3

Name | Species | DOB/ Age

Proposed Caregiver | Email | Phone Number

Proposed Trustee | Email | Phone Number

CHILDREN - *(IF applicable)*

CHILD #1

☐ Select if child is receiving or may be eligible to receive any form of government assistance.

☐ Select if child is born/adopted of this Relationship.

☐ Select if child is born/adopted prior of this Relationship.

_____
Name

_____
Age Marital Status

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

CHILD #2

☐ Select if child is receiving or may be eligible to receive any form of government assistance.

☐ Select if child is born/adopted of this Relationship.

☐ Select if child is born/adopted prior of this Relationship.

_____
Name

_____
Age Marital Status

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

CHILD #3

☐ Select if child is receiving or may be eligible to receive any form of government assistance.

☐ Select if child is born/adopted of this Relationship.

☐ Select if child is born/adopted prior of this Relationship.

_____
Name

_____
Age Marital Status

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

CHILD #4

☐ Select if child is receiving or may be eligible to receive any form of government assistance.

☐ Select if child is born/adopted of this Relationship.

☐ Select if child is born/adopted prior of this Relationship.

_____
Name

_____
Age Marital Status

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

GRANDCHILDREN - ***(IF applicable. Attach additional sheets if necessary)***

GRANDCHILD #1

☐ Select if grandchild is receiving or may be eligible to receive any form of government assistance.

_____
Name Age

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

_____
Name of Parent

GRANDCHILD #2

☐ Select if grandchild is receiving or may be eligible to receive any form of government assistance.

_____
Name Age

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

_____
Name of Parent

GRANDCHILD #3

☐ Select if grandchild is receiving or may be eligible to receive any form of government assistance.

_____
Name Age

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

_____
Name of Parent

GRANDCHILD #4

☐ Select if grandchild is receiving or may be eligible to receive any form of government assistance.

_____
Name Age

_____
Address

_____
Email

_____
Phone No. [ ] Home [ ] Cell

_____
Name of Parent

Please circle your answer "Yes" or "No" *(providing additional information where applicable):*

CLIENT:

ARE YOU A U.S. CITIZEN? Yes No

If no, please indicate Country of Citizenship: _____

ARE YOU IN GOOD HEALTH? Yes No

If no, please indicate the diagnosis of your ailment(s):

_____

_____

HAVE YOU HAD ANY RECENT HOSPITALIZATIONS: Yes No

If yes, please indicate date(s):

_____

DO YOU HAVE ANY PLANNED OR CURRENT PLACEMENT IN A NURSING HOME OR ASSISTED LIVING FACILITY?:

Yes No If yes, please indicate name of nursing home or facility: _____

DO YOU HAVE ANY LONG-TERM CARE INSURANCE? Yes No

If yes, please indicate name of insurance company: _____

DO YOU HAVE ANY INSURANCE WHICH SUPPLEMENTS MEDICARE Yes No

If yes, please indicate the name of supplemental insurance company: _____

ARE YOU A VETERAN OF THE UNITED STATES ARMED FORCES? Yes No

SPOUSE/ CIVIL UNION/ DOMESTIC PARTNER:

ARE YOU A U.S. CITIZEN? Yes No

If no, please indicate Country of Citizenship: _____

ARE YOU IN GOOD HEALTH? Yes No

If no, please indicate the diagnosis of your ailment(s):

_____

_____

HAVE YOU HAD ANY RECENT HOSPITALIZATIONS: Yes No

If yes, please indicate date(s):

_____

DO YOU HAVE ANY PLANNED OR CURRENT PLACEMENT IN A NURSING HOME OR ASSISTD LIVING FACILITY?:

Yes No If yes, please indicate name of nursing home or facility: _____

DO YOU HAVE ANY LONG-TERM CARE INSURANCE? Yes No

If yes, please indicate name of insurance company: _____

DO YOU HAVE ANY INSURANCE WHICH SUPPLEMENTS MEDICARE Yes No

If yes, please indicate the name of supplemental insurance company: _____

ARE YOU A VETERAN OF THE UNITED STATES ARMED FORCES? Yes No

ADDITIONAL INFORMANTION:

Family/Corporate Attorney _____Phone#_____

Accountant _____Phone#_____

Financial Planner/Broker _____Phone#_____

Banker _____Phone#_____

Insurance Agent _____Phone#_____
Homeowners
_____Phone#_____
Auto
_____Phone#_____
Life

What advice or services do you need to discuss today (*check all that apply*)?

☐ Estate Planning: *Last Will and Testament, Durable Power of Attorney, Advance Medical Directive, Trust/Pet Trust*

☐ Medicaid Planning/Elder Care Services: *Medicaid Applications, Asset Protection Plans, Nursing Home Contract Review*

DESIGNATION OF REPRESENTATIVE(S)/AGENT(S)

List Names, in order of preference, of proposed parties to be named as your authorized representatives (where applicable):

CLIENT:

Durable Power of Attorney (Attorney-in-Fact):
1._____
2._____
3._____

Advanced Medical Directive (Agent):
1._____
2._____
3._____

Funeral Agent/Representative:
1._____
2._____
3._____

Executor(s):
1._____
2._____
3._____

Trustee(s):
1._____
2._____
3._____

Guardian(s) of minor children: 1._____

2._____

3._____

List names of any proposed beneficiaries to be named (family members, friends, charities):

_____

_____

_____

_____

SPOUSE/ CIVIL UNION/ DOMESTIC PARTNER:

Durable Power of Attorney (Attorney-in-Fact): 1._____

2._____

3._____

Advanced Medical Directive (Agent): 1._____

2._____

3._____

Funeral Agent/Representative: 1._____

2._____

3._____

Executor(s): 1._____

2._____

3._____

Trustee(s): 1._____

2._____

3._____

Guardian(s) of minor children: 1._____

2._____

3._____

List names of any proposed beneficiaries to be named (family members, friends, charities):

_____

_____

_____

_____

ESTATE & MEDICAID PLANNING CLIENT ASSET INFORMATION

Type of Asset:	None	Name on Account	Jointly: Yes or No	Beneficiary listed: Yes or No	Loans/ Liabilities: Yes or No	Estimated Value Of Asset
Checking Account(s)						
Savings Account(s)						
Money Market Account(s)						
CD's 1 2 3 4						
Real Estate (list addresses): Timeshares, land, etc)						
1						
2						
3						
Business Interests:						
Name of Company						
Mutual Funds						
Stocks:						
Bonds:						
Vehicles: (Make, Model, Year)						
1						
2						
3						
Personal Effects:						
Anticipated Inheritances:						
Pending Litigation: Y or N						
Qualified Funds:						
IRA's						
401k's						
TIAA/CREF						
Savings Plans						
Qualified Annuities						

Non-qualified Annuities or IRA's						
Life Insurance						
Miscellaneous						

MONTHLY INCOME

	CLIENT	**SPOUSE**
Description of Income:		
Net Salary or Wages:		
Social Security Income:		
Pension:		
Other Income:		
Total Income:		

GIFTING

Gifts made in excess of $3,000 per month (total of all gifts made in the same month) to someone other than your spouse within the past sixty (60) months (including transfers of real estate):

Name of Recipient	Date of Gift	Amount

**While Timothy J. Rice, Esquire, The Law Office of Timothy J. Rice and Timothy Rice Estate and Elder Law Firm ("TREEL") and its associates furnish this "Estate and Medicaid Planning Questionnaire" to prospective clients in advance of an initial planning consultation, no attorney-client relationship is implied with the transmission or completion of this form. An attorney-client relationship is not established until such time as a Firm-issued retainer agreement has been signed by the prospective client(s), and, if applicable, a retainer paid for services to be rendered after the initial planning consultation. Completion of this form indicates that you have read these terms and agree with them.*