TULLY LAW GROUP

ELDER CARE AND ESTATE PLANNING

HONOR & PROTECT

Confidential Planning Questionnaire

Please RETURN this Questionnaire 3 days prior to your Consultation.

<u>Complete Client 1</u>
if a single individual.

<u>Complete Client 1 and Client 2</u>
if spouses or partners.

Please do the best you can and call if you have any questions.

Thank you!

(631) 424-2800
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Your Planning Goals

Please identify your reasons for planning and the areas you would like to learn more about in our meeting. Please select all that apply.

Preserve and maximize assets

- ☐ By minimizing taxes during your life (income & capital gains taxes, estate taxes on inheritances you expect to receive)
- ☐ By minimizing or eliminating estate taxes upon your death (up to 50% of your assets and life insurance benefits)
- ☐ By reducing estate administration costs through probate avoidance
- ☐ Avoid or limit Medicaid claims on your assets should you require long-term care
- ☐ Ensure that a special needs beneficiary has assets that are protected from government seizure while retaining eligibility for needed services
- ☐ By ensuring that your assets are passed to your descendants and not given away to outsiders, such as divorcing spouses, creditors or the government

Protect yourself and your spouse

- ☐ From malpractice or other creditor claims
- ☐ From Guardianship proceedings (aka “living probate”) if you or your partner become incapacitated
- ☐ From probate delays and stress upon your death or the death of your spouse/partner
- ☐ From hospital policies requiring life sustaining procedures when you would rather not endure them
- ☐ From healthcare decisions made by people other than those you trust most
- ☐ From nursing homes and paying for long-term care needs

Protect your children or other beneficiaries

- ☐ From predators who can discover inheritance amounts and target young or vulnerable beneficiaries
- ☐ From claims of divorced spouses
- ☐ From malpractice claims, for beneficiaries who work in professional services
- ☐ From other creditors' claims (such as car accident plaintiffs)
- ☐ From the stress and delays of the average 12 month process of probate
- ☐ From financial immaturity resulting in a quick loss of an inheritance
- ☐ From sharing assets with heirs you would rather disinherit
- ☐ *For parents:* from relatives who would be poor, abusive or even dangerous guardians or from foster care
- ☐ *For parents:* from acquaintances and relatives who should not be allowed alone with your children
- ☐ *For special needs beneficiaries:* from losing valuable government benefits

Taking charge and getting organized for the unexpected

- ☐ Get your legal and financial life more organized than ever before
- ☐ Get clear on your estate planning objectives and available options for your planning
- ☐ Benefit a charitable organization or activity
- ☐ *For parents:* by providing guidelines for how your children should be supported while their assets are in trust
- ☐ *For special needs beneficiaries:* By providing instructions, people, and assets to support your special needs beneficiaries above a poverty life style
- ☐ *For businesses owners:* By providing for the orderly continuation and transfer of family business interests rather than a distress sale

Personal Information

Client 1 Name: _____

Date of Birth: _____ Age: _____ US Citizen: Yes No

US Veteran: Yes No Dates of Service: _____ Active or Retired Police, Fire, EMS: Yes No

Social Security No. : (only if requested by attorney) _____

Address: _____

Home Phone: _____ Cell/Work Phone:_____

Email: _____

Client 2 Name: _____

Date of Birth: _____ Age: _____ US Citizen: Yes No

US Veteran: Yes No Dates of Service: _____ Active or Retired Police, Fire, EMS: Yes No

Social Security Number: (only if requested by attorney) _____

Address: _____

Home Phone: _____ Cell/Work Phone: _____

Email: _____

Are you married? Yes No Is this a second marriage? Yes No

Are you widowed? Yes No Date of Death: _____ State: _____

Are you currently divorced and single? Yes No Year of Final Divorce: _____

Children

Do you have Children? Yes No How Many? _____

Are any children from a previous marriage? Yes No Name(s): _____

Has a child predeceased you? Yes No Name(s): _____

If yes, date of death: _____

Was he / she married at the time? Yes No Did he / she have children? Yes No

Please complete the below information for your children. If you need more space, please continue on the back or a separate sheet of paper.

Child # 1 Name: _____ Age: _____

Address: _____

Cell Phone: _____ Email: _____

Married? Yes No Divorced? Yes No Children? Yes No

Child # 2 Name: _____ Age: _____

Address: _____

Cell Phone: _____ Email: _____

Married? Yes No Divorced? Yes No Children? Yes No

Child # 3 Name: _____ Age: _____

Address: _____

Cell Phone: _____ Email: _____

Married? Yes No Divorced? Yes No Children? Yes No

Do you have grandchildren? Yes No How Many? _____

Are any children or grandchildren adopted or step? Yes No

If yes, name(s): _____

Do any of your children or grandchildren have any health issues, special needs or disabilities? Yes No

If yes, name(s): _____

Are any of your children or grandchildren receiving government benefits? Yes No

If yes, name(s): _____

Do any of your children or grandchildren have any financial or personal issues (poor marriage, creditors, addictions, gambling, etc.)? Yes No

If yes, name(s): _____

Health

MEDICAL:

Do you have any medical issues? If yes, please list the issues/diagnoses:

Client 1: _____

_____

Client 2: _____

_____

COGNITIVE:

Are there diagnoses or other concerns with memory or understanding, overall mental capacity?

Client 1: Yes No

Diagnosis: _____ Medications? _____

Client 2: Yes No

Diagnosis: _____ Medications? _____

CHRONIC / LONG TERM CARE:

Do you require assistance with any of the below Activities of Daily Living (ADLs)?

	Client 1:		**Client 2:**	
Transferring from bed/ chair	Yes	No	Yes	No
Walking	Yes	No	Yes	No
Toileting	Yes	No	Yes	No
Bathing	Yes	No	Yes	No
Grooming	Yes	No	Yes	No
Dressing	Yes	No	Yes	No
Eating (not cooking)	Yes	No	Yes	No

If you are a US Veteran, do you have a service-connected disability? Yes No

Financial

Real Estate

Primary Residence - If Owned

Owner(s) on Deed: _____

Fair Market Value (FMV):$_____ Mortgage Balance: $ _____

Purchase Price: _____ Year Purchased: _____

Have you made capital improvements to this home? Yes No

Do you own other Real Estate in New York? Yes No

Owner(s) on Deed: _____

Fair Market Value (FMV):$_____ Mortgage Balance: $ _____

Purchase Price: _____ Year Purchased: _____

Have you made capital improvements to this home? Yes No

Do you own other Real Estate outside of New York? Yes No

Owner(s) on Deed: _____

Fair Market Value (FMV):$_____ Mortgage Balance: $ _____

Purchase Price: _____ Year Purchased: _____

Have you made capital improvements to this home? Yes No

Are any of these properties co-op apartments? Yes No

Do you own other properties? If so, please write the details on the back or a separate sheet and bring in the deeds.

Primary Residence – If You Rent

Monthly Rent $_____ Inclusive of Utilities? Yes No

Bank / Credit Union Accounts

(Checking, Savings, CD's, Money Market)

1. Bank: _____ Owner: _____

   Type of Account: _____ Balance: _____

2. Bank: _____ Owner: _____

   Type of Account: _____ Balance: _____

3. Bank: _____ Owner: _____

   Type of Account: _____ Balance: _____

4. Bank: _____ Owner: _____

   Type of Account: _____ Balance: _____

Do you have a safe deposit box? Yes No

Owner: _____ Bank: _____

Investments

(Stocks, Bonds, Mutual Funds – NOT Retirement)

1. Company: _____ Owner(s): _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

2. Company: _____ Owner(s): _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

3. Company: _____ Owner(s): _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

4. Company: _____ Owner(s): _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

Retirement Accounts

(IRA's, 401k's, 403b's, TSA's, Qualified Annuities)

1. Company: _____ Owner: _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

2. Company: _____ Owner: _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

3. Company: _____ Owner: _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

Education / Minor's Accounts

(529's, UGMA/UTMA,etc.)

1. Company: _____ Owner: _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

2. Company: _____ Owner: _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

3. Company: _____ Owner: _____

   Type of Account: _____ Beneficiary: _____ Balance: $ _____

Life Insurance

1. Company: _____ Owner(s): _____

   Whole or Term: _____ Beneficiary: _____

   Cash Value: $ _____ Death Benefit: $ _____

2. Company: _____ Owner(s): _____

   Whole or Term: _____ Beneficiary: _____

   Cash Value: $ _____ Death Benefit: $ _____

3. Company: _____ Owner(s): _____

   Whole or Term: _____ Beneficiary: _____

   Cash Value: $ _____ Death Benefit: $ _____

Non-Qualified Annuities

1. Company: _____ Owner: _____

   Deferred / Immediate: _____ Beneficiary: _____ Balance: $ _____

2. Company: _____ Owner: _____

   Deferred / Immediate: _____ Beneficiary: _____ Balance: $ _____

Do you a have Pre-Paid funeral arrangement? Yes No

Is it Irrevocable or Revocable? Irrevocable Revocable

Do you have burial plots? Yes No

Business Assets

Do you own an interest in a business? Yes No

Is it a family business? Yes No

Are there any Partners? Yes No

If Yes, who? _____

What type of entity is it? Sole Proprietorship C Corp. S Corp. LLP/LLC

Does the business entity own assets? _____

If Yes, what: _____

Are there any business agreements? _____

Are there any Gross Sales? _____ Estimate Net Annual Sales? _____

Is there a CPA for this business, if so, who? _____

Miscellaneous Property

Do you have items of significant value? jewelry, antiques, art, collections: Yes No

Debts

Is any money owed to you? Yes No

Do you have debt besides the mortgage(s) on your home? Yes No

Income

Who	Type (Soc. Sec./Pension/RMD's etc)	Monthly Amount
1. _____	_____	$ _____
2. _____	_____	$ _____
3. _____	_____	$ _____
4. _____	_____	$ _____

If a Pension and are married, are there any survivor benefits for your spouse/partner? Yes No

Gifting

Have you gifted any money over the last 5 years? Yes No

If yes, have you filed a Gift Tax Return? Yes No (*If yes, please bring a copy*)

Long Term Care Insurance

Do you have Long Term Care Insurance? Yes No (*if yes, please bring a copy*)

Health Insurance

Do you have private "employer" health insurance? Yes No

Do you have health benefits through a former employer? Yes No

Do you have Medicare A? Yes No

Do you have Medicare B? Yes No

Do you have Medicare Advantage C? Yes No

Do you have Medicare Prescription D? Yes No

Do you have New York EPIC? Yes No

Do you have Medicaid? Yes No

Do you have a Medicare Supplemental Policy? Yes No

If yes, which Plan (A – N)? _____

Important Family Questions

Do you have a will, trust, or other estate planning document? *Please furnish a copies*	Yes	No
Are you making payments pursuant to a divorce or property settlement order? *Please furnish a copy*	Yes	No
If married, have you and your spouse signed a pre- or post-marriage contract? *Please furnish a copy*	Yes	No
Do you own any separate property from your spouse?	Yes	No

If so: _____

Do you support any charitable organizations now that you wish to make provisions for at the time of your death?	Yes	No

If so: _____

Are you (or your spouse/partner) currently the beneficiary of anyone else's trust?	Yes	No

If so: _____

Do you (or your spouse/partner) expect to receive in the future any gifts, inheritances or lawsuit settlement or judgment?	Yes	No

If so: _____

Advisors

Accountant: _____ Phone: _____

Financial Advisor: _____ Phone: _____

Life Insurance Agent: _____ Phone: _____

Other: _____ Phone: _____

Important Decisions Makers & People to Help

Guardian for Minor Children

If you have minor children, please name those you would select to serve as Guardian if you were to pass away:

Name, Address, Telephone Number
1.
2.

Executor and Trustee

After your passing, who do you want to serve as Executor and/or Trustee and make decisions regarding the management and distribution of your assets to your beneficiaries?

Client 1	Client 2
Name, Address, Telephone Number	Name, Address, Telephone Number
1.	1.
2.	2.
3.	3.

Power of Attorney

If you were incapacitated, who do you want to make legal and financial decisions on your behalf?

Client 1	Client 2
Name, Address, Telephone Number	Name, Address, Telephone Number
1.	1.
2.	2.
3.	3.

Health Care Proxy

If you were unable to make your own health care decisions about medical treatments and end of life concerns, who would you want to make those decisions for you?

Client 1	Client 2
Name, Address, Telephone Number	Name, Address, Telephone Number
1.	1.
2.	2.
3.	3.

Living Will Decisions (leave blank if unsure and want more info)	**Client 1:**		**Client 2:**	
Do you want your life prolonged by artificial means or measures?	Yes	No	Yes	No
Do you want to donate your organs and tissues, etc. upon your passing?	Yes	No	Yes	No
Would you like to provide any specific instructions about what should happen to your remains upon your death? (burial, cremation, celebration of life)	Yes	No	Yes	No

If so: _____

Legacy

We believe that an inheritance is more than just your financial assets and we help clients convey their values, family traditions, hopes and memories in a tailored Legacy Will.

	Client 1:		**Client 2:**	
Do you wish to leave a Legacy for your loved ones?	Yes	No	Yes	No