CONFIDENTIAL

SPECIAL NEEDS PLANNING PERSONAL INFORMATION QUESTIONNAIRE

The purpose of this Personal Information Questionnaire is to help prepare for our upcoming consultation. This preparation provides us with important personal and family information about the person in need of care, their family and their trusted advisors. The last page of this questionnaire asks for an estimated value of the estate assets. Complete answers will help enable us to most effectively advise you.

It will be very helpful if you can complete and return this Personal Information Questionnaire to our office prior to our initial consultation meeting.

Law Office of

KIM WINOKUR PLC

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PERSONAL INFORMATION

(Please Print)

Person in Need of Services

Date Completed _____

Full Legal Name_____

Print their name as it is signed on legal documents_____

Nickname_____ Birth date_____Social Security Number_____

Home address_____City_____State_____Zip_____

Home Telephone(___)_____County of Residence_____

Employer_____ Position_____Business Telephone (___)_____

Business address_____City_____State_____ Zip_____

❑ Married:_____ ❑ Divorced: Date_____ ❑ Widowed: Date_____ ❑ Single

❑ U.S. Citizen ❑ Lived in the following states: CA, WA, NV, AZ, NM, TX, ID, LA or WI

Spouse

Name _____

Home address_____City_____State_____Zip_____

Home Telephone (___)_____ Business Telephone (___)_____

Person Seeking Legal Counsel

Name _____ Relationship _____

Home address_____City_____State_____Zip_____

Home Telephone (___)_____ Business Telephone (___)_____

FAMILY INFORMATION

(This includes parents, children, siblings and others caring for SN Individual)

Individual #1: Full Legal Name_____ ❑ Male ❑ Female
Nickname_____ Birth date_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home telephone_____ Work telephone _____ County of Residence_____

❑ Married ❑ Divorced ❑ Widowed ❑ Single Spouse's Name: _____

Individual #2: Full Legal Name_____ ❑ Male ❑ Female
Nickname_____ Birth date_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home telephone_____ Work telephone _____ County of Residence_____

❑ Married ❑ Divorced ❑ Widowed ❑ Single Spouse's Name: _____

Individual #3: Full Legal Name_____ ❑ Male ❑ Female
Nickname_____ Birth date_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home telephone_____ Work telephone _____ County of Residence_____

❑ Married ❑ Divorced ❑ Widowed ❑ Single Spouse's Name: _____

Individual #4: Full Legal Name_____ ❑ Male ❑ Female
Nickname_____ Birth date_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home telephone_____ Work telephone _____ County of Residence_____

❑ Married ❑ Divorced ❑ Widowed ❑ Single Spouse's Name: _____

Individual #5: Full Legal Name_____ ❑ Male ❑ Female
Nickname_____ Birth date_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Home telephone_____ Work telephone _____ County of Residence_____

❑ Married ❑ Divorced ❑ Widowed ❑ Single Spouse's Name: _____

Please include other individuals on the back or an additional sheet as necessary.

CARE STATUS

What is the diagnosis? _____

_____

_____

Is the person in need of care competent to express his/her wishes? Yes _____ No _____

Who is providing care now? _____

_____

_____

_____

How is care being paid for? _____

_____

If known, what does person in need of care want to have happen now ? _____

_____

_____

_____

How and where is that documented? _____

_____

_____

What does family want? (Note if there are conflicts) _____

_____

_____

_____

Please provide the following information / documentation:

Copy of assessment, care plan, recent medical reports (if available).

Copy of contact information for all medical and care providers.

Copies of all estate planning documents (if available):

Will, Trust, Durable Power of Attorney, Patient Advocate Designation (Living Will).

Copies of Court documents if Guardian and/or Conservator appointed.

IMPORTANT FAMILY QUESTIONS

Please Check "Yes" or "No" for Your Answer	YES	NO
Does person needing services have a child with learning disability?		
Does person needing services have a child who receives governmental support or benefits?		
Do any of their children have special education, medical, or physical needs?		
Are any of their children institutionalized?		
Is person in need of services or their spouse receiving social security, disability, or other governmental benefits?		
Does person in need of services provide primary or other major financial support to adult children?		
Is person in need of services making payments pursuant to a divorce or property settlement agreement? (Please furnish a copy.)		
Has person in need of services signed a pre- and/or post-marriage contract? (Please furnish a copy.)		
Has person in need of care or their spouse ever filed Federal or State gift tax returns? (Please furnish a copy.)		
Has person in need of services completed Health Care Powers of Attorney or Living Wills? (Please furnish copies.)		
Has person in need of services completed wills, trusts, or estate planning? (Please furnish copies.)		
Is person in need of services a United States citizen?		
If you answered "NO," is he or she a resident or a non-resident alien?		

Government Benefits

Medicaid ____ YES ____ NO CASE # _____

Medicare ____ YES ____ NO CASE# _____

SSI ____ YES ____ NO

SSDI ____ YES ____ NO

For all benefits checked "YES"- Please provide a copy of Medicaid and/or Medicare card, or evidence of SSI or SSDI payment if applicable.

Medicaid (Family Independence Agency) Information

Name of caseworker assigned to file: _____

Address of FIA office: _____

_____

Telephone Number: _____

Please provide a copy of recent communications from FIA (i.e., approval letter, verification request, etc...) including a copy of information submitted to FIA (annual account, etc...)

Community Mental Health Information

Name of worker assigned to file: _____

Address of CMH office: _____

_____

Telephone number: _____

Please provide a copy of recent communications from CMH (i.e., person centered plan)

Social Security Information

Name of caseworker assigned to file: _____

Office Address: _____

_____

Telephone Number: _____

OTHER PROFESSIONAL ADVISORS

Name of CPA: _____

Company_____

Address_____City_____State_____Zip_____

Phone # _____ Fax # _____ E-Mail:_____

Name of Financial Advisor: _____

Company_____

Address_____City_____State_____Zip_____

Phone # _____ Fax # _____ E-Mail:_____

Name of Family Attorney: _____

Law Firm_____

Address_____City_____State_____Zip_____

Phone # _____ Fax # _____ E-Mail:_____

Name of Stock Broker: _____

Company_____

Address_____City_____State_____Zip_____

Phone # _____ Fax # _____ E-Mail:_____

Name of Life Insurance Agent: _____

Company_____

Address_____City_____State_____Zip_____

Phone # _____ Fax # _____ E-Mail:_____

Name of Personal Banker: _____

Company_____

Address_____City_____State_____Zip_____

Phone # _____ Fax # _____ E-Mail:_____

ESTIMATED ASSET VALUATION SHEET FOR PERSON IN NEED OF CARE

ASSETS*	*AMOUNT*	
	Individual	**Joint**
Cash Accounts		
Investment Accounts		
Stocks		
Automobiles and Recreational Vehicles		
Retirements Plans		
Pension Plans		
Life Insurance Policies		
Annuities		
Bonds		
Monies Owed to You		
Homestead		
Other Real Property		
Oil, Gas, and Mineral Interests		
Business Interests: (S Corp, LLC, Partnership)		
Sole Proprietorship Interests		
Anticipated Inheritance, Gift, or Judgment		
Pre-Paid Funeral/Burial Costs/Plots		
Other Assets		
TOTAL ASSETS		

LIABILITIES	*AMOUNT*	
Loans payable		
Accounts payable		
Real estate mortgages payable		
Loans against life insurance		
Unpaid taxes		
Other obligations		
TOTAL LIABILITIES		
NET ESTATE		

MONTHLY INCOME	
Social Security, pension, other regular income	