

ESTATE & FINANCIAL INFORMATION QUESTIONNAIRE

Date: _____

Person supplying answers to these questions:

Client Other (Relationship: _____)

If other: Name _____

Address: _____

Phone: Day: _____ Night: _____ Mobile: _____

Fax: _____ Email: _____

Client Name: (First, Middle, Last)	
Date of Birth:	Social Security No:
Home Address:	
County:	Email:
Phone (Home):	Phone (Work):
Phone (Mobile):	Fax:
Mailing Address (if different from above):	
Living Arrangements: <input type="checkbox"/> Owner Occupied: <input type="checkbox"/> Rented Home or Apartment: <input type="checkbox"/> With Relatives: <input type="checkbox"/> Group Home or ICF-MR Facility: <input type="checkbox"/> Assisted Living Facility: <input type="checkbox"/> Nursing Home:	
Who else lives there (if not institution):	
Citizenship: <input type="checkbox"/> U.S. <input type="checkbox"/> Resident Alien <input type="checkbox"/> Neither	
Marital History: <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed Date of Death: _____ <input type="checkbox"/> Divorced Date of Divorce: _____ County of Divorce: _____ Name(s) of previous spouse(s): _____	

Your Family

Do you have one or more living children? Yes No

Do you have any grandchildren who are children of a deceased child of yours? Yes No

Do you know of a person with a disability to whom you might consider making gifts?

Yes No If yes, name: _____

List below you children. If a child of yours has died, also list their children (your grandchildren):

Full Name	Address	Phone Numbers	Disabled? ¹	Age
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	

Who now is providing significant assistance to you?

Nobody Name(s): _____

Address & phone, if not provided above: _____

Attorney use only:

Notes regarding family and other sources of support, conflict, or difficulty _____

² A person is "disabled" for this purpose if he or she is unable, due to physical or mental disability, to engage in substantial gainful employment that exists in significant numbers in the national economy. If the person is presently receiving Social Security Disability, Supplemental Security Income (SSI), or Medicaid assistance for long term care, he or she does meet this requirement.

Nursing Home/Hospital Information (if applicable)

Please include all nursing homes, hospitals, and rehabilitation facilities utilized for the same spell of illness or injury as that currently in treatment (if any).

Date In	Date Out	Name of Facility and Location	NH	Hosp	Rehab

If you are in a nursing home now, is Medicare currently paying for your stay? Yes No

Anticipated Future Need for Long-Term Care				Life Expectancy
Hospital:	<input type="checkbox"/> > 6 mos	<input type="checkbox"/> 1-6 mos	<input type="checkbox"/> < 1 mo	<input type="checkbox"/> No Known Limit <input type="checkbox"/> Less than 6 months according to Dr. <input type="checkbox"/> Uncertain whether limited <input type="checkbox"/> Other: _____
Nursing Home:	<input type="checkbox"/> > 6 mos	<input type="checkbox"/> 1-6 mos	<input type="checkbox"/> < 1 mo	
Assisted Living:	<input type="checkbox"/> > 6 mos	<input type="checkbox"/> 1-6 mos	<input type="checkbox"/> < 1 mo	
Home Care:	<input type="checkbox"/> > 6 mos	<input type="checkbox"/> 1-6 mos	<input type="checkbox"/> < 1 mo	

Your Health

Diagnoses: _____

Medication(s): _____

Nursing help you are getting now: _____

Activities you need help with (check all that apply):

- | | | | |
|-----------------------------------|-------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Bathing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Transferring |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Continence | <input type="checkbox"/> Medications | <input type="checkbox"/> Walking |

Known limitation on life expectancy?

Yes No If yes, please explain: _____

Mental Status (Check all that apply, even if only from time to time):

- Recognize friends & family: Yes No Sometimes
- Can describe own money & property: Yes No Sometimes
- Can name all close family members: Yes No Sometimes

Comments: _____

Your Medical Expenses

Medical Expense	Cost Per Month
<input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Home Care <input type="checkbox"/> Sitter	
Medications (out of pocket expense):	
<input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D	
Medicare Supplement Insurance Company Medicare Advantage Plan:	
<input type="checkbox"/> Other Medical Insurance Type: _____ Company: _____	
<input type="checkbox"/> Long-Term Care Insurance:	
Other out of pocket Medical Expenses:	

Military Service

Have you or your spouse ever been in the armed forces? Yes No

Veteran's Name	Service No./Branch	Dates of Service	Type of Discharge*
			H <input type="checkbox"/> G <input type="checkbox"/> D <input type="checkbox"/>
			H <input type="checkbox"/> G <input type="checkbox"/> D <input type="checkbox"/>
			H <input type="checkbox"/> G <input type="checkbox"/> D <input type="checkbox"/>

* H=Honorable G=General D=Dishonorable

Information concerning your residence, if owned by you:

Deed is in the name of

- You alone (100% ownership)
- You and _____, and you own _____% of the residence.
Relationship, if any, of co-owner(s): _____

Estimated fair market value (tax appraised value if known): \$ _____

Amount owned on the mortgage: Nothing (paid off) Presently owe \$ _____

Location: _____

Who lives there now?

- You alone
- You and _____ Relationship: _____
- Renters paying \$ _____ per month
- Persons not paying rent: _____ Relationship: _____

Does unmarried son or daughter live there? Yes No

Does a son or daughter who has provided care for more than 2 years live there? Yes No

Other information concerning the residence that may be important: _____

Your Other Assets

Resource Description	Value
Most Valuable Vehicle ² :	
Vehicle 2:	
Gravesite/Marker(s): Name of Cemetery:	
Prepaid Funeral Contracts:	
Prepaid Funeral Goods:	
Household Goods:	
Checking Accounts (Name(s) of Bank(s) or Credit Union(s)):	
Savings <i>not</i> in IRAs (Name(s) of Bank(s) or Credit Union(s)):	
CDs <i>not</i> in IRAs (Name(s) of Bank(s) or Credit Union(s)):	
Money Markets <i>not</i> in IRAs (Name(s) of Bank(s) or Credit Union(s)):	
Stocks/Bonds <i>not</i> in IRAs (Brokerage or Security Name):	

² Enter year, make, model for all vehicles. Include any motorcycles, boats, trailers, or RVs.

Resource Description					Value
Untaxed Retirement Accounts (such as 401Ks, IRAs, & "Qualified" Annuities) Company Name:					
Tax-Deferred (Non-qualified) Annuities Company Name:					
Safe Deposit Box, Bank Locations, & Contents:					
Patient Trust Fund:					
Life Insurance:					
Company Name:	Policy #	Insured	Owner	Face Value	Surrender Value
Notes Receivable:					Value
Real Estate (Other Than Residence):					
<input type="checkbox"/> Tax-Appraised Value if any or <input type="checkbox"/> 40X avg. Monthly Income					
Gas/Oil/Mineral Rights:					
Other (Describe):					
Attorney use only					
Total Countable Resources:					

Debts:	Amount
Homestead Debt:	
Other Secured Debt:	
Unsecured Debt:	
Unsecured Debt:	
Attorney use only	Total debts:
	Net (after debts) countable resources:

Your Income

Please indicate **monthly** income:

FIXED INCOME:	Value
Social Security Net Monthly Payment:	
Medicare Part B Premium:	
Medicare Part D Premium:	
SSI:	
VA:	
Railroad Retirement:	
Civil Service Annuities:	
Other Retirement:	
Pension:	
Annuities:	
Other Fixed Income:	
Attorney use only:	Total fixed:
VARIABLE INCOME:	
Gross Earned Income:	
Interest:	
Dividends:	
Stocks & Bonds:	
Rental/Notes:	
Oil & Gas:	
Farm Income:	
Other Income:	
Attorney use only	Total variable:
	Total income:

POSSIBLE DEDUCTIONS:	
Taxes withheld from income (monthly):	
Monthly health insurance premium:	

Other questions concerning your assets

Are you the beneficiary of a trust?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transferred assets to a trust?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anticipate an inheritance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Received an inheritance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

(If Yes, be sure anything you still own is listed among your other assets above).

Have you transferred cash or anything as a gift, for less than fair market value, in the last 5 years?

Yes No

If Yes, give the following information as to each transfer:

Recipient: _____ Asset description (if not cash): _____ Date: _____ Value of cash or other asset: \$ _____ Received in return: <input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> \$ _____ Cash <input type="checkbox"/> Other: _____ worth \$ _____ Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain purpose(s) of transfer: _____
Recipient: _____ Asset description (if not cash): _____ Date: _____ Value of cash or other asset: \$ _____ Received in return: <input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> \$ _____ Cash <input type="checkbox"/> Other: _____ worth \$ _____ Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain purpose(s) of transfer: _____
Recipient: _____ Asset description (if not cash): _____ Date: _____ Value of cash or other asset: \$ _____ Received in return: <input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> \$ _____ Cash <input type="checkbox"/> Other: _____ worth \$ _____ Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain purpose(s) of transfer: _____

Questions concerning legal documents

Document	Do you have this document?	Attorney use only: Document Adequate?
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Durable Power of Attorney (Financial)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Power of Attorney for Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Directive to Physicians (Living Will)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Court Appointed Guardianship of <input type="checkbox"/> Estate <input type="checkbox"/> Person	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Living (Revocable) Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Documents funding Living Trust (deeds, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain

Attorney use only—Notes concerning legal documents:

Attorney use only:

Goals of client:

- Acquire the best possible long term care, within their financial ability
- Keep in the family certain assets: _____
- _____
- Acquire effective wills and powers of attorney
- Protect a child or other person with a disability
- Other: _____
- _____
- _____
- _____

Checklist for Plan Preparation:

How to obtain documents to copy:

- Client provided all copies needed.
- We copied all at first conference.
- Returned original documents with plan after copying.
- Call _____ to pick up documents after copying.
- Have documents hand delivered to _____ after copying.

How to deliver plan:

- Call _____ to pick up at our office.
- Have plan delivered by FedEx or UPS to _____
- Mail plan to the following: _____
- Email plan to the following:

When complete, please print and mail or drop off to:

The Law Office of Raymond E. Brown, LLC
1910 Towne Centre Blvd
Suite 250
Annapolis, MD 21401

***Or upload your completed saved form to our secure client portal
(call 443-554-9944 to request access)***