

# ESTATE & FINANCIAL INFORMATION QUESTIONNAIRE

Date: \_\_\_\_\_

**Person supplying answers to these questions:**

Husband     Wife     Other (Relationship: \_\_\_\_\_)

If other: Name \_\_\_\_\_

Address : \_\_\_\_\_

Phone: Day: \_\_\_\_\_ Night: \_\_\_\_\_ Mobile: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

<b>Husband</b>	<b>Wife</b>
Full Name:	Full Name:
Date of Birth:	Date of Birth:
Social Security No.:	Social Security No.:
Home Address:	Home Address:
County:	County:
Phone (Day): Phone (Evening): Phone (Mobile): Email:	Phone (Day): Phone (Evening): Phone (Mobile): Email:
Living Arrangements: <input type="checkbox"/> Own Home <input type="checkbox"/> Rented Home or Apartment <input type="checkbox"/> Rent—Assisted Living <input type="checkbox"/> No Rent—Home of _____ <input type="checkbox"/> Nursing Facility: _____ Who else lives there (if not Nursing Home or ALF):	Living Arrangements: <input type="checkbox"/> Own Home <input type="checkbox"/> Rented Home or Apartment <input type="checkbox"/> Rent—Assisted Living <input type="checkbox"/> No Rent—Home of _____ <input type="checkbox"/> Nursing Facility: _____ Who else lives there (if not Nursing Home or ALF):
Citizenship: <input type="checkbox"/> U.S. <input type="checkbox"/> Resident Alien <input type="checkbox"/> Neither	Citizenship: <input type="checkbox"/> U.S. <input type="checkbox"/> Resident Alien <input type="checkbox"/> Neither
Marital History: <input type="checkbox"/> Married for _____ years <input type="checkbox"/> No previous Marriage <input type="checkbox"/> Previously married: Name of previous spouse _____ previous marriage ended in <input type="checkbox"/> Divorced: Date: _____ County of Divorce: _____ <input type="checkbox"/> Death: date:	Marital History: <input type="checkbox"/> Married for _____ years <input type="checkbox"/> No previous Marriage <input type="checkbox"/> Previously married: Name of previous spouse _____ previous marriage ended in <input type="checkbox"/> Divorced: Date: _____ County of Divorce: _____ <input type="checkbox"/> Death: date:

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

Full Name	Address	Phone Numbers	Disabled? <sup>1</sup>	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	

<sup>1</sup> 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.

**Who now is providing significant assistance for**

Husband— <input type="checkbox"/> Names(s): _____ Wife— <input type="checkbox"/> Names(s): _____
<p><b>Attorney use only:</b>                  Notes regarding family and other sources of support, conflict, or difficulty</p> <hr/> <hr/> <hr/> <hr/>

**Nursing Home/Hospital Information to Husband (if applicable)**

Please include all nursing homes, hospitals, and rehabilitation facilities utilized by the husband.

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

**Nursing Home/Hospital Information to Wife (if applicable)**

Please include all nursing homes, hospitals, and rehabilitation facilities utilized by the husband.

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

If either is in a nursing home now, is Medicare currently paying for the stay?  Yes  No

**Anticipated Future Need for Long-Term Care**

Husband				Wife			
Hospital:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo	Hospital:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo
Nursing Home:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo	Nursing Home:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo
Assisted Living:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo	Assisted Living:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo
Home Care:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo	Home Care:	<input type="checkbox"/> >6mos	<input type="checkbox"/> 1-6mos	<input type="checkbox"/> <1mo

**Life Expectancy**

Husband		Wife	
<input type="checkbox"/> No Known Limit	<input type="checkbox"/> Less than 6 months according to Dr.	<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: _____	<input type="checkbox"/> Uncertain whether limited	<input type="checkbox"/> Other: _____

Do you (or either of 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

<b>Physical/Mental Conditions of Husband:</b>	<b>Physical/Mental Conditions of Wife:</b>
<b>Diagnoses:</b>	<b>Diagnoses:</b>
<p><b>Activities you need help with</b> (check all that apply):</p> <p><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</p> <p>Comments:</p>	<p><b>Activities you need help with</b> (check all that apply):</p> <p><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</p> <p>Comments:</p>
<p><b>Mental Status</b> (check all that apply, even if only from time to time):</p> <p>Recognize friends &amp; Family:  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Sometimes</p> <p>Can describe own money &amp; property:  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Sometimes</p> <p>Can name all close family members:  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Sometimes</p> <p>Comments:</p>	<p><b>Mental Status</b> (check all that apply, even if only from time to time):</p> <p>Recognize friends &amp; Family:  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Sometimes</p> <p>Can describe own money &amp; property:  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Sometimes</p> <p>Can name all close family members:  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Sometimes</p> <p>Comments:</p>
<p><b>Attorney use only:</b></p> <p>Medicaid "medical necessity"?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p> <p>Capacity to sign POAs?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p> <p>Capacity to sign Will?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p> <p>Capacity to make gifts?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p>	<p><b>Attorney use only:</b></p> <p>Medicaid "medical necessity"?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p> <p>Capacity to sign POAs?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p> <p>Capacity to sign Will?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p> <p>Capacity to make gifts?  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Uncertain</p>

### Your Medical Expenses

Medical Expense	Husband	Wife
<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 (or HMO) Company (husband): _____ Company (wife): _____		
<input type="checkbox"/> Long-Term Care Insurance:		
Other out of pocket Medical Expenses:		

### Military Service

Have you or your spouse, parent(s), or deceased child(ren) ever been in the armed forces?

Yes     No

Please provide the following:

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:**  Husband  Wife  Both Husband & Wife

**Other ownership:** \_\_\_\_\_

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

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

**Location:** \_\_\_\_\_

**Who lives there now?**  Husband  Wife  Both Husband & Wife

Other \_\_\_\_\_

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:

**Information Concerning Your Other Assets**

**Definition of "Snapshot Date" and "Snapshot Value":** On the first day of the first month when one spouse goes into a "medical institution" and stays at least 30 days, the Medicaid program takes a "snapshot" of all assets of both husband and wife. A "medical institution" is defined as hospital, nursing home, or rehabilitation facility (but not an Assisted Living Facility), and when there is a transfer from one medical institution directly to another, the time spent in both facilities counts toward the 30 days. Therefore, if one spouse went into a hospital on September 30, 2020 then transferred directly to a nursing home on October 10, 2020 and stayed in the nursing home at least through October 30, 2020, the "snapshot date" is September 1, 2020. *If there is not a "snapshot date" for either spouse, disregard the "snapshot date" question below. If both have snapshot dates, fill in the blank for both spouses.*

**\*\*\*\*If uncertain about Snapshot Date, we will help determine it at your conference\*\*\*\***

"Snapshot Date" for Husband, if any: \_\_\_\_\_

"Snapshot Date" for Wife, if any: \_\_\_\_\_

Note: When you place values on the assets below, provide net values (subtract anything you own on the property). Life insurance is valued at Cash Surrender Value.

<b>Resource Description</b>	<b>Title<sup>2</sup></b>	<b>Snapshot Value</b>	<b>Most Recent Value Amount</b>	<b>Most Recent Value Date</b>
Residence:				
Most Valuable Vehicle <sup>3</sup> :				
Vehicle 2:				
Gravesite/Marker(s):				
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)):				

<sup>2</sup> Indicate "H" for Husband, "W" for Wife, "HW" for both Husband and Wife. Leave blank if uncertain. Please explain on the back if someone other than Husband and/or Wife own an interest in any asset.

<sup>3</sup> Enter year, make, model for all vehicles. Include any motorcycles, boats, trailers, or RVs.

Resource Description	Title	Snapshot Value	Most Recent Value Amount	Most Recent Value Date	
Stocks/Bonds <i>not</i> in IRAs (Brokerage or Security Name):					
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:					
<b>Life Insurance:</b>					
Company Name:	Insured	Policy Owner	Face Value	Snapshot Value	Current Cash Value



Resource Description	Title	Snapshot Value	Most Recent Value Amount	Most Recent Value Date
<b>Notes Receivable:</b>				
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):				
<b>Attorney use only</b>				
Total Countable Resources:				

**Your Debts**

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

**Do you own one or more credit card?**  Yes  No

## Your Income

Please indicate monthly income:

<b>FIXED INCOME:</b>	<b>Husband</b>	<b>Wife</b>
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:		
<i>Attorney use only</i> <span style="float: right;">Total fixed:</span>		
<b>VARIABLE INCOME:</b>		
Gross Earned Income:		
Interest:		
Dividends:		
Stocks & Bonds:		
Rental/Notes:		
Oil & Gas:		
Farm Income:		
Other Income:		
<i>Attorney use only</i> <span style="float: right;">Total variable:</span>		
<b>POSSIBLE DEDUCTIONS:</b>		
Taxes withheld from income (monthly):		
Monthly health insurance premium:		

**Other questions concerning your assets**

Husband	Wife
<p><b>Are you the beneficiary of a trust?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><b>Transferred assets to a trust?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><b>Anticipate an inheritance?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><b>Received an inheritance?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>(If Yes, be sure anything you still own is listed among your other assets above).</p>	<p><b>Are you the beneficiary of a trust?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><b>Transferred assets to a trust?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><b>Anticipate an inheritance?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><b>Received an inheritance?</b> <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>(If Yes, be sure anything you still own is listed among your other assets above).</p>
<p><b>Have you transferred cash or anything as a gift, for less than fair market value, in the last 5 years?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If Yes, give the following as to each transfer:</b></p>	<p><b>Have you transferred cash or anything as a gift, for less than fair market value, in the last 5 years?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If Yes, give the following as to each transfer:</b></p>
<p>Recipient: _____</p> <p>Asset: _____</p> <p>Date: _____ Value: \$ _____</p> <p>Received in return:</p> <p><input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> Cash \$ _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If No, explain purpose(s) of transfer:</p>	<p>Recipient: _____</p> <p>Asset: _____</p> <p>Date: _____ Value: \$ _____</p> <p>Received in return:</p> <p><input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> Cash \$ _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If No, explain purpose(s) of transfer:</p>
<p>Recipient: _____</p> <p>Asset: _____</p> <p>Date: _____ Value: \$ _____</p> <p>Received in return:</p> <p><input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> Cash \$ _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If No, explain purpose(s) of transfer:</p>	<p>Recipient: _____</p> <p>Asset: _____</p> <p>Date: _____ Value: \$ _____</p> <p>Received in return:</p> <p><input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> Cash \$ _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If No, explain purpose(s) of transfer:</p>
<p>Recipient: _____</p> <p>Asset: _____</p> <p>Date: _____ Value: \$ _____</p> <p>Received in return:</p> <p><input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> Cash \$ _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If No, explain purpose(s) of transfer:</p>	<p>Recipient: _____</p> <p>Asset: _____</p> <p>Date: _____ Value: \$ _____</p> <p>Received in return:</p> <p><input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> Cash \$ _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If No, explain purpose(s) of transfer:</p>

**Questions concerning legal documents**

<b>Document</b>	<b>Husband</b>	<i>Attorney use only: Adequate?</i>	<b>Wife</b>	<i>Attorney use only: Adequate?</i>
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	<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	<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	<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	<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/Estate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<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	<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	<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
- Protect Family Assets/Inheritance: \_\_\_\_\_
- 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)***