Revised 12/2022
EP/MP - Single

Date: _____

RICE & QUATTRONE, PC
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ESTATE AND MEDICAID PLANNING QUESTIONNAIRE

PLEASE PRINT LEGIBLY

Note: **If you are completing this form for a parent, other family member, or friend, please supply information for such person, not yourself, but supply your name, address and telephone number and email address in this space below:**

_____ _____
Your Name Telephone Number

_____ _____
Address Email Address (if any)

CLIENT NAME: _____
First MI Last

_____
Also Known As (if any)

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

HOME ADDRESS: _____

_____

_____

HOME TELEPHONE: _____ CELL: _____

EMAIL: _____

OCCUPATION: _____

EMPLOYER NAME: _____

ADDRESS: _____

WORK TELEPHONE: _____

HAVE YOU EVER BEEN MARRIED? Yes____ No____

If yes, please list any applicable date(s) and method of termination (death, divorce, annulment) of prior marriages, including names of former spouse(s):

_____

CHILDREN (if any):

CHILD #1

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #2

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #3

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #4

_____
Name

_____
Address

_____
Telephone No. Email Age DOB Marital Status

_____
Born of this Marriage or prior Marriage?

CHILD #5

Name

Address

Telephone No. Email Age DOB Marital Status

Born of this Marriage or prior Marriage?

GRANDCHILDREN (if any):

GRANDCHILD #1

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #2

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #3

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #4

Name

Address

Age DOB Marital Status

Name of Parent

GRANDCHILD #5

Name

Address

Age DOB Marital Status

Name of Parent

ARE ALL YOUR CHILDREN AND GRANDCHILDREN IN GOOD HEALTH? Yes ____ No ____

ARE ANY OF YOUR CHILDREN OR GRANDCHILDREN RECEIVING SSI OR OTHER FORM OF GOVERNMENT ASSISTANCE? Yes ____ No ____

YOUR SIBLINGS (if applicable):

Sibling #1

Name

Address

Age DOB Marital Status

Sibling #2

Name

Address

Age DOB Marital Status

Sibling #3

Name

Address

Age DOB Marital Status

Sibling #4

Name

Address

Age DOB Marital Status

Sibling #5

Name

Address

Age DOB Marital Status

ARE YOU A UNITED STATES 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):

PLEASE INDICATE IF YOU HAVE HAD ANY RECENT HOSPITALIZATIONS: Yes ____ No ____

_____

_____

PLEASE INDICATE IF THERE IS ANY PLANNED OR CURRENT PLACEMENT IN A NURSING HOME OR ASSISTED LIVING FACILITY: Yes ____ No ____

_____

DO YOU HAVE LONG TERM CARE INSURANCE? Yes ____ No ____

If so, please indicate from which company, what the monthly or daily benefit is and the terms:

_____

DO YOU HAVE HEALTH INSURANCE THAT SUPPLEMENTS MEDICARE ("Medigap")?

Yes ____ No ____

If yes, please indicate which company: _____

Amount of Premium: $_____

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

IF YOU ARE A VETERAN, ARE YOU RECEIVING TRI-CARE? Yes ____ No ____

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior Gold? Yes ____ No ____

If you are a Pennsylvania resident are you currently receiving benefits under the PACE program?
Yes ____ No ____

HOW WERE YOU REFERRED TO OUR FIRM? _____

PLEASE LIST NAME, ADDRESS AND TELEPHONE NUMBER OF THE FOLLOWING:

Family/Corporate Attorney _____

Accountant _____

Financial Planner/Broker _____

Banker _____

Insurance Agents _____
Homeowners

_____
Auto

_____
Life

PLEASE INDICATE WHETHER YOU HAVE EXECUTED ANY OF THE FOLLOWING ESTATE PLANNING DOCUMENTS:

	No	Yes – Date Signed	Do you want to make changes?
Will			
Living Will (a/k/a Advance Directive or Healthcare Power of Attorney)			
Financial Power of Attorney			
Trust			

ASSETS

Name: _____

Date: _____

NON-RETIREMENT ASSETS (Fill in Amounts/Values in boxes; check left column if no such asset)					
	✓ if None	**In Your Name Only**	**In Your Name - With Beneficiary (POD or ITF)**	**Joint with Someone Else**	**Loans/Mortgages against - liabilities**
Checking Account(s)					
Savings Account(s)					
Money Market Account(s)					
CD(s)					
Residence					
Other Real Estate:					
(State: _____)					
Time Shares					
Businesses					
(Name: _____)					
Mutual Funds (non-retirement)					
Stocks					
Bonds					
Automobiles (make/model/year)					
Personal Effects					
Anticipated Inheritances					
Pending Litigation					
Other					
TOTALS					

Assets: Name: _____

Date: _____

RETIREMENT (TAX-QUALIFIED) ASSETS (Fill in Amounts/Values)					
	✓ if None	OWNER	INSURED / ANNUITANT	BENEFICIARY	VALUE/DEATH BENEFIT
IRA'S (including rollovers)					
401(K)					
403(b)					
TIAA/CREF					
Savings Plans					
Qualified Annuities					
NON-QUALIFIED ANNUITIES					
TOTALS					

HAVE YOU BEEN GIVEN A POWER OF APPOINTMENT IN A TRUST CREATED BY ANOTHER PERSON OR IN ANOTHER PERSON'S ESTATE? Yes ____ No ____

Assets:

Name: _____

Date: _____

LIFE INSURANCE

INSURED	COMPANY	POLICY #	WHOLE LIFE OR TERM?	FACE VALUE	CASH SURRENDER VALUE	DEATH BENEFIT	BENEFICIARY

Name: _____

Date: _____

MONTHLY INCOME

Net Salary or Wages	$
Social Security	$
Pension	$
Annuity Income	$
Other Income	$
TOTAL INCOME	$

GIFTS

Gifts and transfers of property made to someone other than your spouse within the past 60 months (including transfers of real estate, e.g. adding a child's name to a deed)

RECIPIENT	DATE	AMOUNT
		$
		$
		$
		$
		$
		$
		$

ANTICIPATED MONTHLY ASSISTED LIVING OR NURSING HOME EXPENSES (if applicable)

Name of Nursing Home/Assisted Living Facility	
Date of Admission	
Average Monthly Bill	$