

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

Referred by: \_\_\_\_\_

# Pfalzgraf Beinhauer & Menzies, LLP

ATTORNEYS AT LAW  
455 Cayuga Road, Suite 600  
Buffalo, NY 14225  
(716) 204-1055  
Fax (716) 204-1080

## Elder Law Planning Questionnaire (For Married Persons)

### ***PART A: PERSONAL INFORMATION***

#### ***HUSBAND:***

Full Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address \_\_\_\_\_

U.S. Citizen: Yes No

Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

General Health Information: \_\_\_\_\_

List Date(s) and Location of Hospitalization(s) During the Past Year: \_\_\_\_\_

Medicare: Yes No

Veteran: Yes No

Major Medical or Other Health Insurance: Yes No

If YES please describe: \_\_\_\_\_

Long-Term Care Insurance: Yes No

If YES please describe: \_\_\_\_\_

**WIFE:**

Full Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address \_\_\_\_\_

U.S. Citizen: Yes No

Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

General Health Information: \_\_\_\_\_

List Date(s) and Location of Hospitalization(s) During the Past Year: \_\_\_\_\_

Medicare: Yes No

Veteran: Yes No

Major Medical or Other Health Insurance: Yes No

If YES please describe: \_\_\_\_\_

Long-Term Care Insurance: Yes No

If YES please describe: \_\_\_\_\_



**PART B: MONTHLY INCOME**

<i>INCOME DESCRIPTION</i>	<i>HUSBAND'S MONTHLY INCOME</i>	<i>WIFE'S MONTHLY INCOME</i>	<i>JOINT MONTHLY INCOME</i>
Net Salary or Wages (Take Home Pay)			
Social Security Benefits			
Retirement Benefits			
Interest			
Dividends			
Other			
<b>TOTAL MONTHLY INCOME</b>			

If there is a pension, please list the gross pension amount and the name of the company or governmental entity paying the pension:

**Name of Entity:** \_\_\_\_\_ **Gross Amount \$** \_\_\_\_\_

**PART C: ASSETS**

Please insert the approximate value of each asset/liability in the appropriate space:

<i>ASSET</i>	<i>HUSBAND</i>	<i>WIFE</i>	<i>JOINT</i>	<i>LIABILITY</i>
Primary Residence				
Other Real Estate				
Personal Effects				
Automobile(s)				
Business Interest				
Checking Account(s)				
Savings Account(s)				

ASSET	HUSBAND	WIFE	JOINT	LIABILITY
Money Market Account(s)				
Certificate(s) of Deposit				
Mutual Funds				
Stocks				
Bonds				
Annuities				
Cash Surrender Value Total of Life Insurance (List Specific Values in Part F)				
IRA Account(s)				
TOTAL				

Is there a safe deposit box? YES NO If yes, Location: \_\_\_\_\_

Box Number \_\_\_\_\_ Joint Tenant or Deputy: \_\_\_\_\_

Address of any real property other than personal residence:

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

What is your cost basis for your personal residence? \_\_\_\_\_

Do you expect to inherit any property in the near future from any person? YES NO

If YES, List Particulars: \_\_\_\_\_

**PART D: LIFE INSURANCE**

(1) Company: \_\_\_\_\_ Type: \_\_\_\_\_

Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_ Insured: \_\_\_\_\_

Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

(2) Company: \_\_\_\_\_ Type: \_\_\_\_\_

Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_ Insured: \_\_\_\_\_

Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

(3) Company: \_\_\_\_\_ Type: \_\_\_\_\_

Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_ Insured: \_\_\_\_\_

Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

(4) Company: \_\_\_\_\_ Type: \_\_\_\_\_

Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_ Insured: \_\_\_\_\_

Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

It is important to know the cash surrender value of your life insurance policy. To obtain the cash surrender value of the policies, please call your insurance agent, or call the insurance company directly.

**PART E: GIFTS**

Please list any gifts made by either spouse in excess of \$1,000 to an individual other than your spouse within the since February of 2006:

<i>RECIPIENT</i>	<i>DATE</i>	<i>AMOUNT</i>

**PART F:**

**MISCELLANEOUS INFORMATION**

If either spouse is in a nursing home or contemplates entering a nursing home, please list the following:

**Name of Spouse:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Prognosis:** \_\_\_\_\_

**Course of Treatment:** \_\_\_\_\_

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis:

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

**List monthly charges and source of payment at the present time:** \_\_\_\_\_

**PART G:**

Please furnish our office with copies of the following documents, if applicable:

1. Deed to Home and current County Tax Bill;
2. Deed to other Real Property and County Tax Bill;
3. Copy of Last Will and Testament;
4. Copy of Power of Attorney;
5. Copy of Health Care Proxy;
6. Copy of Long Term Care Insurance Policy; and
7. Copy of any Trust Agreements.