



ELDER AND VETERAN'S LAW QUESTIONNAIRE

Filling out the Questionnaire

- Your Information will be held in ***strictest confidence***.
- You should fill in the full legal names of all people listed in the questionnaire (even if the person will not be specifically mentioned). Please avoid the use of nicknames unless specifically asked for.
- This is a generic questionnaire so if questions do not apply, simply write in N/A.
- If you need more room, please write on the back or use the space provided in the Appendix.

Your documents will be based on the information you provide. To that end, please read and sign the following statement:

I understand that the information I am providing will form the basis of any advice I receive from the attorney. I further understand that my responses to the questionnaire are protected by the attorney-client privilege and will be held in utmost confidence. With these understandings, I affirm that the information provided herein is full, complete and accurate to the best of my present knowledge.

Dated: _____ Signed: _____

Dated: _____ Signed: _____

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 124 4th Avenue South
 Suite 200
 Kent, WA 98032
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ELDER and VETERAN'S LAW QUESTIONNAIRE

PART I: PERSONAL INFORMATION

If possible, please use *full legal names* (first, full middle and last) when asked for names.

Name of Person Completing this Questionnaire, **if not client**:

Name: _____

Relationship to Clients: _____

Client 1: Name: _____

Birth date: _____ SSN: _____ Nickname: _____

If not a US Citizen, what is your citizenship? _____

Are you a veteran? Yes No If yes, dates of active duty and branch: _____

Client 2: Name: _____

Birth date: _____ SSN: _____ Nickname: _____

If not a US Citizen, what is your citizenship? _____

Are you a veteran? Yes No If yes, dates of active duty and branch: _____

Contact Information (Use address you wish to have us contact)

Residential Address: _____

City: _____ State: _____ Zip: _____

County: King Snohomish Pierce Other _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Fax: _____

C1 Cell: _____ C2 Cell: _____

E-mail: _____

Marital Status

Married Single Divorced Widowed Life Partnership

If Married: Date of Marriage: _____ State where Married: _____

PART II: FAMILY INFORMATION

Children:

Please note that "full name" includes full middle name. Please write "dec" after child's name if that child is deceased.

Oldest child *full name*: _____ Nickname: _____
SSN: _____ Birth date: _____ Male Female
Address: _____
City: _____ State: _____ Zip: _____
Related to: Both Husband Wife Child's Spouse's name: _____
Is this child dependent upon you? Yes No Does this child live with you? Yes No

Next child *full name*: _____ Nickname: _____
SSN: _____ Birth date: _____ Male Female
Address: _____
City: _____ State: _____ Zip: _____
Related to: Both Husband Wife Child's Spouse's name: _____
First names of children: _____
Is this child dependent upon you? Yes No Does this child live with you? Yes No

Next child *full name*: _____ Nickname: _____
SSN: _____ Birth date: _____ Male Female
Address: _____
City: _____ State: _____ Zip: _____
Related to: Both Husband Wife Child's Spouse's name: _____
First names of children: _____
Is this child dependent upon you? Yes No Does this child live with you? Yes No

Next child *full name*: _____ Nickname: _____
SSN: _____ Birth date: _____ Male Female
Address: _____
City: _____ State: _____ Zip: _____
Related to: Both Husband Wife Child's Spouse's name: _____
First names of children: _____
Is this child dependent upon you? Yes No Does this child live with you? Yes No

For additional children, please use the last page of the Questionnaire

Does a dependent or family member have special educational, medical or financial needs? Yes No
If Yes, please explain: _____

If any family member is deceased, please write "dec" after his or her name.

Is Client 1 or Client 2 currently in a health care facility Yes No:

Name of facility: _____

Address: _____

Type of facility: _____

Level of care: _____

Date of admission: _____

If you entered this facility from another health care facility, date of your admission to this *initial* facility: _____

Funding source(s): _____

Client 1's health status: _____

If Client 2 is currently in health care facility:

Name of facility: _____

Address: _____

Type of facility: _____

Level of care: _____

Date of admission: _____

If spouse entered this facility from another health care facility, date of admission to this *initial* facility: _____

Funding source(s): _____

Client 2's health status: _____

2. Is anyone (other than the spouse) dependent upon clients for support? If so, please identify the person, and provide some general information as to the reason for, and extent of, support provided.

PROPERTY

Please list all assets you own at fair market value (estimates are OK)

Home: \$ _____

Other Real Estate: \$ _____ (Number of parcels _____)

Checking: \$ _____

Savings: \$ _____

Investments: \$ _____

IRA's/Retirement \$ _____

CD's: \$ _____

Annuities: \$ _____

Life Insurance: \$ _____

Burial Plans: \$ _____

Mutual Funds: \$ _____

Businesses: \$ _____

Vehicles: \$ _____

Personal Property: \$ _____

Other: \$ _____ Please describe: _____

5. Do either Client 1 or Client 2 expect to inherit significant property or have a power of appointment under anyone else's will or trust? Yes [] No []. If yes, please explain:

6. List Client 1 and Client 2's debts, if any, other than mortgage(s).

To Whom?	Amount Due
-----------------	-------------------

7. Are either Client 1 or Client 2 the beneficiary of any trust? Yes [] No [].

If yes, please enclose a photocopy of a signed version, if available, or provide whatever information you can on the terms and conditions of the trust, identity of the current trustee, amount of principal, etc.

8. Is any of the property or income of Client 1 or Client 2 the subject of a legal proceeding or ownership dispute, under a lien or court order, or is otherwise inaccessible or nonmarketable? Yes [] No []. If yes, please explain briefly:

9. During the last 36 months, have either Client 1 or Client 2 made any large gifts (\$1,000 or more in value), placed any property into trust, transferred any real estate or other property for less than fair market value, or removed or added names to joint accounts? Yes [] No []. If yes, please list each action and explain when and why the transfer was made:

10. Please provide the following information regarding the *monthly* income of Client 1 and Client 2:

	Client 1	Client 2
Salary:	\$ _____	\$ _____
Pension:	\$ _____	\$ _____
Annuities:	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
SSI:	\$ _____	\$ _____
Investment Income	\$ _____	\$ _____
Interest Income:	\$ _____	\$ _____
Other:	\$ _____	\$ _____
Total monthly	\$ _____	\$ _____

11. If Client 1 or Client 2 are in a medical facility, please answer the following questions, as you may be entitled to support for living expenses.

How much do you pay each month for:

\$ _____ rent

\$ _____ mortgage (including principal and interest)

\$ _____ property taxes

\$ _____ homeowner's or tenant's insurance

\$ _____ required maintenance charges (for condominium or cooperative)

If you live in an apartment or condominium and have to pay separately for heat, what is the average cost per month? \$ _____; for electricity? \$ _____; for natural gas? \$ _____; for telephone? \$ _____.

12. (i) Does a child, parent, sibling, or other family member currently live in Client 1 or Client 2's home? Yes [] No [].

(ii) If you answered yes to (i), is any portion of Client 1 or Client 2's income directly or indirectly used to provide all or a portion of their support? Yes [] No [].

(iii) If you answered yes to (ii), describe the circumstances, the reasons for the arrangement, and how it is being handled financially.

(iv) Please provide the following information for each person to whom you or your spouse are furnishing support:

Name	Relationship	Date of birth	Amount of monthly support
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12. Please check the appropriate line and provide the following information regarding Client 1 and Client 2's health insurance:

_____ Medicare for yourself (Number: _____)

_____ Medicare for spouse (Number: _____)

_____ Medicare Supplemental Insurance for self
(Company: _____)
(Number: _____)

_____ Medicare Supplemental Insurance for spouse
(Company: _____)
(Number: _____)

_____ Medicaid for yourself (Number: _____)

_____ Medicaid for your spouse (Number: _____)

_____ Other health insurance for yourself?
(Company: _____)
(Number: _____)

_____ Other health insurance for your spouse?
(Company: _____)
(Number: _____)

13. Did either Client 1 or Client 2 come to the marriage with significant amounts of property or later individually acquire significant property, other than from work or investment earnings, such as by inheritance? Yes [] No []. If yes, please explain briefly:

14. Have either Client 1 or Client 2, during the last 90 days, had substantial medical expenses, such as nursing home or hospital bills, which have *not* been paid and are not expected to be paid by Medicare, Medigap insurance, long-term care insurance, or other insurance? Yes [] No []. If yes, please provide details and explain:

15. Have any of Client 1 or Client 2's children or brothers or sisters lived with them during the last two years? Yes [] No [].

If so, please describe the circumstances of the individual, the reason for the arrangement, and how it was handled financially:

16. To the extent not already noted above, please describe any significant changes that Client 1 or Client 2 anticipate occurring at any time over the course of the next five years with respect to their: (i) personal, marital, or family situation, (ii) employment, or (iii) financial situation as it relates to their level of income, debt, or assets.

17. Please provide the following monthly expense estimates:

Health Care Expenses

How Much?

Medical (to extent not reimbursed by insurance)

Nursing home fees

Medical insurance

Physician services

Optometrist fees

Dental treatment

Psychological counseling

Physical therapy

Occupational therapy

Home health aides

Visiting nurses

Personal care services

Eyeglasses

Hearing aids

Prescription medicines

Nonprescription medicines

Medical appliances

Other:

Miscellaneous

- Companion services _____
- Respite care _____
- Adult day care _____
- Dependent care _____
- Entertainment _____
- Homemaker services _____

PART III: MISCELLANEOUS INFORMATION

Who referred you to Albertson Law Group? _____

If you weren't referred, how did you hear about our firm? _____

Current Planning

Please place a checkmark beside each document that you currently have:

- | | |
|---|---|
| <input type="checkbox"/> Will | <input type="checkbox"/> Revocable Living Trust |
| <input type="checkbox"/> Community Property Agreement | <input type="checkbox"/> Written Financial Plan (Please bring in) |
| <input type="checkbox"/> Prenuptial Agreement | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Durable Power of Attorney | _____ |
| <input type="checkbox"/> Health Care Power of Attorney | |
| <input type="checkbox"/> Living Will | |
| <input type="checkbox"/> Irrevocable Trust(s) Please explain: | |

Advisors

Attorney

Name: _____

Firm: _____

Address: _____

City, State Zip: _____

Phone: _____

Fax: _____

E-mail: _____

Accountant

Insurance Agent

Name: _____

Firm: _____

Address: _____

City, State Zip: _____

Phone: _____

Fax: _____

E-mail: _____

Financial Planner

APPENDIX

Additional Children:

Next child *full* name: _____ Nickname: _____
SSN: _____ Birth date: _____ Male Female
Address: _____
City: _____ State: _____ Zip: _____
Related to: Both Husband Wife Child's Spouse's name: _____
First names of children: _____

Next child *full* name: _____ Nickname: _____
SSN: _____ Birth date: _____ Male Female
Address: _____
City: _____ State: _____ Zip: _____
Related to: Both Husband Wife Child's Spouse's name: _____
First names of children: _____

Next child *full* name: _____ Nickname: _____
SSN: _____ Birth date: _____ Male Female
Address: _____
City: _____ State: _____ Zip: _____
Related to: Both Husband Wife Child's Spouse's name: _____
First names of children: _____

If you still need more room, please use the back of this page.

Additional Information:

Topic	Information
_____	_____ <input type="checkbox"/>
_____	_____ <input type="checkbox"/>
_____	_____ <input type="checkbox"/>
_____	_____ <input type="checkbox"/>
_____	_____ <input type="checkbox"/>
_____	_____ <input type="checkbox"/>
_____	_____ <input type="checkbox"/>
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_____	_____ <input type="checkbox"/>