



HAWKINS ELDER LAW
MARRIED CLIENT ESTATE PLANNING QUESTIONNAIRE



We want to serve you effectively without wasting your time or burdening you with details. Your responses to this questionnaire will help us serve you as quickly and effectively as possible.

1. How did you hear about Hawkins Elder Law?

- Checkboxes for: Newspaper, Internet, Family/Friends, Banker, Financial Advisor, Accountant, Nursing Home, Other (please tell us)

2. General Information About You:

Your Mailing Address: _____

Street Address (if different from mailing address): _____

Client 1

Client 2 (Spouse or Significant Other)

First Name: _____

First Name: _____

Middle Name or Initial: _____

Middle Name or Initial: _____

Last Name: _____

Last Name: _____

Preferred Name/Nickname: _____

Preferred Name/Nickname: _____

County of Residence: _____

E-mail: _____

E-mail: _____

County of Residence: _____

Home Telephone: _____

Home Telephone: _____

Work Telephone: _____

Work Telephone: _____

Cell Telephone: _____

Cell Telephone: _____

Date of Birth: _____

Date of Birth: _____

Prior Deceased Spouse? Yes [] No []

Prior Deceased Spouse? Yes [] No []

Deceased Spouse's Name: _____

Deceased Spouse's Name: _____

Date of Death: _____

Date of Death: _____

3. Financial Advisor's Name: _____ Telephone: _____

Firm Name: _____ E-mail: _____

4. Tax Advisor's Name: _____ Telephone: _____

Firm Name: _____ E-mail: _____

5. Client 1's Children (complete all applicable blanks and checkboxes)

First Name: _____ Middle Name/Initial: _____ Last Name: _____
Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____
Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __
E-mail Address: _____ Best Phone Number: _____
Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____
Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____
Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __
E-mail Address: _____ Best Phone Number: _____
Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____
Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____
Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __
E-mail Address: _____ Best Phone Number: _____
Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____
Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____
Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __
E-mail Address: _____ Best Phone Number: _____
Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____
Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____
Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __
E-mail Address: _____ Best Phone Number: _____
Mailing Address: _____

****Please make sure to list any children who are deceased. **Please add additional pages if necessary***

6. Client 2's Children (complete all applicable blanks and checkboxes)

First Name: _____ Middle Name/Initial: _____ Last Name: _____

Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____

Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __

E-mail Address: _____ Best Phone Number: _____

Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____

Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____

Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __

E-mail Address: _____ Best Phone Number: _____

Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____

Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____

Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __

E-mail Address: _____ Best Phone Number: _____

Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____

Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____

Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __

E-mail Address: _____ Best Phone Number: _____

Mailing Address: _____

First Name: _____ Middle Name/Initial: _____ Last Name: _____

Son Daughter Birth Date: _____ Deceased Date of Death if Deceased: _____

Disabled Not Disabled If disabled, please describe the type and extent of the disability: _____

Married Single Has Children Number of Children: __ 1st Child's Age: __ Last Child's Age: __

E-mail Address: _____ Best Phone Number: _____

Mailing Address: _____

****Please make sure to list any children who are deceased. **Please add additional pages if necessary***

7. Who do you want to receive your assets when you die? It is your choice whether to include or exclude your children, other family members, friends, or nonprofit organizations that you want to help. For beneficiaries other than your spouse or children, please include each person's city and relationship to you. Also, tell us if a person is to receive a specific asset (such as personal belongings, money, or land) when you die. Add pages if needed.

Client 1:			
Beneficiary Name	City	Type of Asset	Relationship to You

**Add additional pages if necessary*

Client 2:			
Beneficiary Name	City	Type of Asset	Relationship to You

**Add additional pages if necessary*

8. Who do you want to manage your legal or financial affairs if you become disabled or unable to act?

Client 1's People to Manage Personal Business:		Client 2's People to Manage Personal Business:	
First Choice:		First Choice:	
Second Choice:		Second Choice:	

Client 1's People to Manage Personal Business:		Client 2's People to Manage Personal Business:	
Third Choice:		Third Choice:	
Fourth Choice:		Fourth Choice:	

****Add additional pages if necessary***

9. Please list the person or people who you would want to make health care decisions for you should you become unable to make those decisions. If you want them to serve at the same time instead of in the order of priority shown in the table below, check this box:

Client 1:		Client 2:	
First Choice:		First Choice:	
Second Choice:		Second Choice:	
Third Choice:		Third Choice:	
Fourth Choice:		Fourth Choice:	

****Add additional pages if necessary***

10. Information about your Income and Assets (Please provide all applicable checkboxes and blanks):

Client 1:	Client 2:
Work Income: \$ _____ Social Security: \$ _____ Pension: \$ _____ Other Income: \$ _____ If you have a vested employee pension, please name the employer: _____ Currently Employed? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you self-employed? Yes <input type="checkbox"/> No <input type="checkbox"/> Business Name: _____ Business Type: _____ Do you own your home? Yes <input type="checkbox"/> No <input type="checkbox"/> Mortgage Loan Balance: \$ _____ Describe real estate that you own, including co-ownership with someone else or in a trust (not including your home or real estate that your corporation or LLC): _____	Work Income: \$ _____ Social Security: \$ _____ Pension: \$ _____ Other Income: \$ _____ If you have a vested employee pension, please name the employer: _____ Currently Employed? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you self-employed? Yes <input type="checkbox"/> No <input type="checkbox"/> Business Name: _____ Business Type: _____ Do you own your home? Yes <input type="checkbox"/> No <input type="checkbox"/> Mortgage Loan Balance: \$ _____ Describe real estate that you own, including co-ownership with someone else or in a trust (not including your home or real estate that your corporation or LLC): _____

Client 1:	Client 2:
If you own any coal, oil, gas or other mineral rights or interests, please check the applicable boxes and describe the rights or interests below, including any royalties that you receive:	If you own any coal, oil, gas or other mineral rights or interests, please check the applicable boxes and describe the rights or interests below, including any royalties that you receive:
Coal <input type="checkbox"/> Description:	Coal <input type="checkbox"/> Description:
Oil <input type="checkbox"/> Description:	Oil <input type="checkbox"/> Description:
Gas <input type="checkbox"/> Description:	Gas <input type="checkbox"/> Description:
Other <input type="checkbox"/> Description:	Other <input type="checkbox"/> Description:
Do you expect to receive an inheritance from anyone? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please explain:	Do you expect to receive an inheritance from anyone? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please explain:
Do you have long term care (i.e. nursing home) insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, what is the insurance company's name? _____	Do you have long term care (i.e. nursing home) insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, what is the insurance company's name? _____

11. Please check the following box that best describes the total value of assets of Client #1 and Client #2 (the attorney just needs a general idea for the initial meeting):

- Less than \$100,000
 \$100,000 - \$500,000
 \$500,000 to \$1,000,000
 \$1,000,000 to \$5,000,000
 \$5,000,000 to \$10,000,000
 \$10,000,000 to \$20,000,000
 More than \$20,000,000

12. Is there any person who may expect to benefit from your estate, and whom you plan to exclude from your estate? (i.e. Do you wish to “disinherit” anyone?) If so, whom?

Client 1:	Client 2:

**Add additional pages if necessary*

13. Have you ever sold, given, or traded a portion of the real estate that you still own (i.e. have you split a tract into 2 or more tracts)? If so, briefly describe the portion you have sold, given, or traded

Client 1:			
Beneficiary Name	Date	Simple Property Description	Value (Estimated)

**Add additional pages if necessary*

Client 2:			
Beneficiary Name	Date	Simple Property Description	Value (Estimated)

**Add additional pages if necessary*

14. In the last five years, have you given any of your assets to your children or anyone else, including money (cash or checks), vehicles, real estate, or personal property? This includes putting someone’s name on a deed or vehicle title.

Client 1:

Beneficiary Name	Date	Simple Property Description	Value (Estimated)

**Add additional pages if necessary*

Client 2:

Beneficiary Name	Date	Simple Property Description	Value (Estimated)

**Add additional pages if necessary*

15. Please use this space to elaborate on any answer you have given above, or to add any information or questions you would like to discuss with the attorney.

Client 1:	Client 2:

**Add additional pages if necessary*