HAWKINS ELDER LAW
MARRIED CLIENTS' 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?

☐ Newspaper Articles ☐ Facebook ☐ Internet Search ☐ Television Ads

☐ Other (Who referred you to us?) _____

2. General Information About You:

Mailing Address: _____

Street Address (if different): _____

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: _____
Military Veteran? Yes ☐ No ☐	Military Veteran? Yes ☐ No ☐
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**: _____

Reset Pg 1 Checkboxes

5. Client 1's Children – Please complete all applicable blanks and checkboxes for each child.

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

Client 1 – Child 1					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:		
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐ Tension/Conflict ☐ Estranged/Broken ☐				
Email Address:		Best Phone Number:			
Mailing Address					

Client 1 – Child 2					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:		
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐ Tension/Conflict ☐ Estranged/Broken ☐				
Email Address:		Best Phone Number:			
Mailing Address					

Reset Pg 2 Checkboxes

Client 1 – Child 3					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:		
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐		
Email Address:		Best Phone Number:			
Mailing Address					

Client 1 – Child 4					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:		
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐		
Email Address:		Best Phone Number:			
Mailing Address					

Reset Pg 3 Checkboxes

Client 1 – Child 5					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:		
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐		If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.			
Description of your parent/child relationship:		Close ☐	Tension/Conflict ☐	Estranged/Broken ☐	
Email Address:		Best Phone Number:			
Mailing Address					

Client 1 – Child 6					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:		
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐		If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.			
Description of your parent/child relationship:		Close ☐	Tension/Conflict ☐	Estranged/Broken ☐	
Email Address:		Best Phone Number:			
Mailing Address					

Reset Pg 4 Checkboxes

6. Client 2's Children – Same as Client 1? Yes ☐ No ☐ If "yes," skip this section. If "No," please complete all applicable blanks and checkboxes for each child.

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

Client 2 – Child 1				
Name (including middle initial)				
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:	
Disabled? Yes ☐ No ☐		Describe Disability:		
Married? Yes ☐ No ☐				
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.			
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐	
Email Address:		Best Phone Number:		
Mailing Address				

Client 2 – Child 2				
Name (including middle initial)				
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐	If deceased, date of death:	
Disabled? Yes ☐ No ☐		Describe Disability:		
Married? Yes ☐ No ☐				
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.			
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐	
Email Address:		Best Phone Number:		
Mailing Address				

Reset Pg 5 Checkboxes

Client 2 – Child 3					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ ☐		If deceased, date of death:	
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐		
Email Address:		Best Phone Number:			
Mailing Address					

Client 2 – Child 4					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐		If deceased, date of death:	
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐		
Email Address:		Best Phone Number:			
Mailing Address					

Reset Pg 6 Checkboxes

Client 2 – Child 5					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐		If deceased, date of death:	
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐		
Email Address:		Best Phone Number:			
Mailing Address					

Client 2 – Child 6					
Name (including middle initial)					
Son ☐	Daughter ☐	Deceased? Yes ☐ No ☐		If deceased, date of death:	
Disabled? Yes ☐ No ☐		Describe Disability:			
Married? Yes ☐ No ☐					
Has Children? Yes ☐ No ☐	If you plan distributions to grandchildren, please give their full names, birth dates, and parents' names at the end of this questionnaire.				
Description of your parent/child relationship:	Close ☐	Tension/Conflict ☐	Estranged/Broken ☐		
Email Address:		Best Phone Number:			
Mailing Address					

Reset Pg 7 Checkboxes

7. Who do you want to receive your assets when you die? You can choose 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).

Client 1 –Distributions to Beneficiaries:			
After Client 1 & 2 are deceased, equal distributions to children? Yes ☐ No ☐ **If "No," please provide your intended distribution details below:**			
Beneficiary Name	**City**	**Type of Asset**	**Relationship to You**

Add additional pages if necessary

Reset Pg 8 Checkboxes

Client 2 – Specific Distributions to Beneficiaries: Check here if same as Client 1: ☐			
After Client 1 & 2 are deceased, equal distributions to children? Yes ☐ No ☐ **If "No," please provide your intended distribution details below:**			
Beneficiary Name	**City**	**Type of Asset**	**Relationship to You**

Add additional pages if necessary

Reset Pg 9 Checkboxes

8. Who do you want to PAY BILLS and otherwise manage your LEGAL or FINANCIAL BUSINESS if you become disabled or unable to act? <u>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</u>: ☐

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

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. <u>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</u>: ☐

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

10. Information about your MONTHLY Income (Please complete all applicable checkboxes and blanks):

Client 1:		**Client 2:**	
Employment Income:		Employment Income:	
Social Security:		Social Security:	
Pension Income 1:		Pension Income 1:	
Pension 1 Description:		Pension 1 Description:	
Pension 1 Provider:		Pension 1 Provider:	

Client 1:		Client 2:	
Pension Income 2:		Pension Income 2:	
Pension 2 Description:		Pension 2 Description:	
Pension 2 Provider:		Pension 2 Provider:	
Other Income:		Other Income:	
Income Description:		Income Description:	
Currently Employed?	Yes ☐ No ☐	Currently Employed?	Yes ☐ No ☐

11. Information about your Assets (Please complete all applicable checkboxes and blanks):

Are you self-employed?	Yes ☐ No ☐	Are you self-employed?	Yes ☐ No ☐
Business Name:		Business Name:	
Business Type:		Business Type:	
Do you own your home?	Yes ☐ No ☐	Do you own your home?	Yes ☐ No ☐
Mortgage Loan Balance:		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):		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):	
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 ☐	Describe coal interest below:	Coal ☐	Describe coal interest below:
Oil ☐	Describe oil interest below:	Oil ☐	Describe oil interest below:

Reset Pg 11 Checkboxes

Gas ☐ Describe gas interest below:	Gas ☐ Describe gas interest below:
Other mineral interest ☐ Describe below:	Other mineral interest ☐ Describe below:
Do you expect to receive an inheritance from anyone? Yes ☐ No ☐ If so, please explain below:	Do you expect to receive an inheritance from anyone? Yes ☐ No ☐ If so, please explain below:

Does Client 1 or Client 2 have any 401(k), IRA, Roth, or similar (referred to here as "IRA") accounts?			
Client 1:	Yes ☐ No ☐	Client 2:	Yes ☐ No ☐
IRA 1 Balance:		IRA 1 Balance:	
IRA 1 Provider:		IRA 1 Provider:	
IRA 1 Type:		IRA 1 Type:	
IRA 2 Balance:		IRA 2 Balance:	
IRA 2 Provider:		IRA 2 Provider:	
IRA 2 Type:		IRA 2 Type:	
IRA 3 Balance:		IRA 3 Balance:	
IRA 3 Provider:		IRA 3 Provider:	
IRA 3 Type:		IRA 3 Type:	
Client 1 has life insurance (LI)?	Yes ☐ No ☐	Client 2 has life insurance (LI)?	Yes ☐ No ☐
LI Policy 1 Amount:		LI Policy 1 Amount:	
LI Policy 1 Company:		LI Policy 1 Company:	
LI Policy 1 Owner:		LI Policy 1 Owner:	

Reset Pg 12 Checkboxes

LI Policy 1 Insured:		LI Policy 1 Insured:	
LI Policy 2 Amount:		LI Policy 2 Amount:	
LI Policy 2 Company:		LI Policy 2 Company:	
LI Policy 2 Owner:		LI Policy 2 Owner:	
LI Policy 2 Insured:		LI Policy 2 Insured:	
LI Policy 3 Amount:		LI Policy 3 Amount:	
LI Policy 3 Company:		LI Policy 3 Company:	
LI Policy 3 Owner:		LI Policy 3 Owner:	
LI Policy 3 Insured:		LI Policy 3 Insured:	
Do you have US savings bonds?	Yes ☐ No ☐	Do you have US savings bonds?	Yes ☐ No ☐
How many savings bonds?		How many savings bonds?	
Total Savings Bond Value:		Total Savings Bond Value:	
Do you have annuities?	Yes ☐ No ☐	Do you have annuities?	Yes ☐ No ☐
Annuity 1 Amount:		Annuity 1 Amount:	
Annuity 1 Provider:		Annuity line Provider:	
Annuity 2 Amount:		Annuity 2 Amount:	
Annuity 2 Provider:		Annuity 2 Provider:	
Annuity 3 Amount:		Annuity 3 Amount:	
Annuity 3 Provider		Annuity 3 Provider	

Does Client 1 or Client 2 on corporate stock (perhaps in an insurance company or former employer)? If so, please provide copies of stock certificates and recent account statements for each stock account.

Client 1	Yes ☐ No ☐	Client 2	Yes ☐ No ☐
Corporate Stock 1		Corporate Stock 1	
Corporate Stock 2		Corporate Stock 2	

Reset Pg 13 Checkboxes

Corporate Stock 3		Corporate Stock 3	
Corporate Stock 4		Corporate Stock 4	
Corporate Stock 5		Corporate Stock 5	
Do you have long term care (i.e. nursing home) insurance? Yes ☐ No ☐ If "yes," please provide a complete copy of your policy.		Do you have long term care (i.e. nursing home) insurance? Yes ☐ No ☐ If "yes," please provide a complete copy of your policy.	

12. 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 - $1 million	☐
$1 million - $5 million	☐	$5 million - $10 million	☐	More than $10 million	☐

13. Do you plan to exclude someone from receiving your assets, who may expect to benefit from your estate? (i.e. Do you wish to "disinherit" anyone?) If so, please identify the person with a brief explanation.

Client 1:	Client 2:

Add additional pages if necessary

14. 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

Sales, Gifts, or Trades by Client 1:			
Other Person's Name	**Date**	**Simple Property Description**	**Value (Estimated)**

Add additional pages if necessary

Reset Pg 14 Checkboxes

Sales, Gifts, or Trades by Client 2:			
Other Person's Name	**Date**	**Simple Property Description**	**Value (Estimated)**

Add additional pages if necessary

15. 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. Note, there is nothing wrong with giving gifts, but it usually helps us to know about it.

Transfers in Past 5 Years – Client 1:

Beneficiary Name	Date	Simple Property Description	Value (Estimated)

Add additional pages if necessary

Transfers in Past 5 Years – Client 2:

Beneficiary Name	Date	Simple Property Description	Value (Estimated)

Add additional pages if necessary

16. 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*