



LaCava Law Firm, LLC

**CONFIDENTIAL
ESTATE PLANNING
QUESTIONNAIRE**

CLIENT PERSONAL INFORMATION

Client 1

Legal Name: _____

Also known as: _____

Home Address: _____

Home Phone: _____ Cell: _____

E-mail: _____

Birth Date: _____ SS# _____

Citizenship: _____

Previous marriage(s): Yes No

Prior children from previous relationships: Yes No

Are you currently married? Yes No If yes, what is your husband or wife's full legal name? _____

If married, do you and your husband or wife wish to create a joint estate plan with mirroring terms? Yes No (If yes, please fill out the below jointly with your husband or wife. If no, your husband or wife should fill out a separate questionnaire.)

Client 2 (If Applicable)

Legal Name: _____

Also known as: _____

Home Address: _____

Home Phone: _____ Cell: _____

E-mail: _____

Birth Date: _____ SS# _____

Citizenship: _____

Previous marriage(s): Yes No

Prior children from previous relationships: Yes No

EMPLOYMENT INFORMATION

Client 1 Position: _____

Employer: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Client 2 Position: _____

Employer: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Date Completed: _____

YOUR CONCERNS

Please rate the following as to how important they are to you:
(*H* high concern, *M* moderate concern, *L* low concern, *O* no concern, or *N/A* not applicable)

DESCRIPTION	LEVEL OF CONCERN
Desire to get affairs in order and create a comprehensive plan to manage affairs in case of death or disability	H M L O N/A
Providing for and protecting children	
Please provide further details: _____ _____	
Providing for and protecting grandchildren or other loved ones	
Please provide further details: _____ _____	
Planning for a child or family member with disabilities or special needs	
Disinheriting a family member	
Providing for charities at the time of death	
Plan for the transfer and survival of a family business	
Minimizing or reducing estate taxes	
Avoiding probate	
Avoiding guardianship and conservatorship in case of a disability	
Minimizing the risk of will contests or other disputes upon death	
Protecting assets from nursing home costs	
Protecting children's inheritance from bad relationships, financial problems, and addictions	
Maintaining Retirement Plan benefits, such as Individual Retirement Accounts, for future generations	
Providing that your death shall not be unnecessarily prolonged by artificial means or measures	
Protecting Assets from potential creditors	
Other Concerns (Please list below):	

IMPORTANT FAMILY QUESTIONS

(Please check "Yes" or "No" for your answer)

Yes No

Are you receiving social security, disability, or other governmental benefits?

If yes, please explain. _____

Have you been diagnosed with a chronic or life threatening disease?

Do you have a specific diagnosis? If yes, please explain. _____

Are you making payments pursuant to a divorce or property settlement order?

If yes, please furnish a copy of divorce or property settlement agreement.

Have you signed a pre- or post-nuptial contract? ***If yes, please furnish a copy.***

Have you been widowed? ***If a federal estate tax return or a state death tax return was filed, please furnish a copy.***

Have you ever filed a federal or state gift tax return?

If yes, please furnish copies of these returns.

Have you completed previous will, trust, or estate planning documents?

If yes, please furnish copies of these documents.

Do you support any charitable organizations now that you wish to make provisions for at the time of your death? ***If yes, please explain below.***

Do any of your children or grandchildren have financial problems, relationship problems, drug or alcohol problems, and/or spending problems? ***If so, please explain below.***

Are you currently the beneficiary of anyone else's trust?

If so, please explain below. Please also provide the name of the Trust and the name of the Trustee (if known).

Do you provide primary or other major financial support to adult children or others?

If yes, please explain: _____

ADDITIONAL RELEVANT INFORMATION

CHILDREN

(Please provide the full legal name)

CHILD 1

Full Legal Name: _____ DOB _____

Address: _____ Cell Phone: _____

M/F _____ Marital Status: Married Divorced

No. of Children: _____ Full Name of Child's Spouse: _____

Is this child shared with your existing husband or wife? Yes No

If not, please explain further. _____

CHILD 2

Full Legal Name: _____ DOB _____

Address: _____ Cell Phone: _____

M/F _____ Marital Status: Married Divorced

No. of Children: _____ Full Name of Child's Spouse: _____

Is this child shared with your existing husband or wife? Yes No

If not, please explain further. _____

CHILD 3

Full Legal Name: _____ DOB _____

Address: _____ Cell Phone: _____

M/F _____ Marital Status: Married Divorced

No. of Children: _____ Full Name of Child's Spouse: _____

Is this child shared with your existing husband or wife? Yes No

If not, please explain further. _____

CHILD 4

Full Legal Name: _____ DOB _____

Address: _____ Cell Phone: _____

M/F _____ Marital Status: Married Divorced

No. of Children: _____ Full Name of Child's Spouse: _____

Is this child shared with your existing husband or wife? Yes No

If not, please explain further. _____

CHILDREN

(Please provide the full legal name)

CHILD 5

Full Legal Name: _____ DOB _____

Address: _____ Cell Phone: _____

M/F _____ Marital Status: Married Divorced

No. of Children: _____ Full Name of Child's Spouse: _____

Is this child shared with your existing husband or wife? Yes No

If not, please explain further. _____

CHILD 6

Full Legal Name: _____ DOB _____

Address: _____ Cell Phone: _____

M/F _____ Marital Status: Married Divorced

No. of Children: _____ Full Name of Child's Spouse: _____

Is this child shared with your existing husband or wife? Yes No

If not, please explain further. _____

Additional Information on your children:

Do you have any deceased children? Yes No

If yes, please provide provide the full legal name for this deceased child, the date of death, and indicate if your deceased child was survived by any children. If so, please also provide the name(s) and age(s) of any surviving grandchildren:

Do you have any minor foster children? Yes No

If yes, please provide the full legal name and ages for each _____

Are all of your children/grandchildren in good health? Yes No

If yes, please explain: _____

Are any of your children/grandchildren blind or disabled? Yes No

If yes, please explain: _____

Are any of your children/grandchildren receiving SSI, Medicaid or any other form of government benefits? Yes No

If yes, please explain below.

DEPENDENTS OR BENEFICIARIES OTHER THAN YOUR CHILDREN

(If a charity, disregard birth date and relationship)

Beneficiary 1 Name	Birth Date	Relationship
_____	_____	_____
Address: _____		

Comments: _____		

Beneficiary 2 Name	Birth Date	Relationship
_____	_____	_____
Address: _____		

Comments: _____		

Beneficiary 3 Name	Birth Date	Relationship
_____	_____	_____
Address: _____		

Comments: _____		

Beneficiary 4 Name	Birth Date	Relationship
_____	_____	_____
Address: _____		

Comments: _____		

PETS: Do you have pets that you want to provide for after your death? Yes No

If yes, please provide the name of the pet(s) and explain your wishes further:

If so, who do you want to care for your pets: _____

Do you want to leave money for the care of your pets? Yes No If yes, what amount? \$ _____

What do you want done with any amount remaining after your pets have died? _____

ADVISORS	Name	Telephone
Accountant:	_____	_____
Financial Advisor:	_____	_____
Attorney:	_____	_____
Other:	_____	_____

ESTATE PLANNING APPOINTMENTS

WILL:

PERSONAL REPRESENTATIVE: (Upon your death, who do you want to settle your estate?)

1st Choice _____

Name

Address

Phone: _____ Relationship: _____

2nd Choice _____

Name

Address

Phone: _____ Relationship: _____

3rd Choice _____

Name

Address

Phone: _____ Relationship: _____

Please explain in detail how you would like your estates assets to be distributed upon your death.

TRUST:

TRUSTEE: (Upon your death or incapacity while living, who do you want carrying out your instructions for distribution to and, if desired, management of property for your beneficiaries?)

1st Choice _____

Name

Address

Phone: _____ Relationship: _____

2nd Choice _____

Name

Address

Phone: _____ Relationship: _____

3rd Choice _____

Name

Address

Phone: _____ Relationship: _____

Please explain in detail the purpose of the trust, who the beneficiaries are, and how you would like the trust assets to be distributed during your life and upon your death.

GUARDIAN & CONSERVATOR OF MINOR OR DISABLED CHILDREN: (If you have any minor or disabled children at the time of your deaths, who would you want to be responsible for them?)

1st Choice _____

Name

Address

Phone: _____ Relationship: _____

2nd Choice _____

Name

Address

Phone: _____ Relationship: _____

3rd Choice _____

Name

Address

Phone: _____ Relationship: _____

Please provide guidance on your specific wishes for your minor or disabled child or childrens care in the event of your death (Ex: Religious upbringing, education, parenting style of guardian, etc.)

DECISIONS REGARDING BURIAL/CREMATION:

Is it your wish to be buried or cremated? Buried Cremated

Do you have a prepaid plan? Yes No
If yes, please provide details (Ex: funeral home name/location, cemetery name/location, plot number)

Is it your wish to donate any of your organs? Yes No
If yes, please explain further (Ex: organs you want donated), _____

POWER OF ATTORNEY FOR PROPERTY

POWER OF ATTORNEY FOR PROPERTY: (Who would you want to act as your agent for legal or financial decisions during your life if you are unable to do so? Please note that your agent should be at least eighteen (18) years old.

1st Choice _____
Name _____ Address _____
Phone: _____ Relationship: _____

2nd Choice _____
Name _____ Address _____
Phone: _____ Relationship: _____

3rd Choice _____
Name _____ Address _____
Phone: _____ Relationship: _____

Property Agent Powers

Please indicate below what decision making power you wish to grant to your property agent:

Yes No

- Real estate transactions
- Financial institution transactions
- Stock and bond transactions
- Tangible personal property transactions
- Safe deposit box transactions
- Insurance and annuity transactions
- Retirement plan transactions
- Social Security, employment, and military service benefits
- Tax matters
- Claims and litigation
- Commodity and option transactions
- Business operations
- Borrowing transactions
- Estate transactions
- All other property transactions

Additional Property Agent Powers

In addition to the powers granted above, I grant my agent the following powers:

(NOTE: Here you may add any other delegable powers including, without limitation, power to make gifts, exercise powers of appointment, name or change beneficiaries or joint tenants or revoke or amend any trust specifically referred to below.)

Property Agent Restrictions

Please check the boxes below to indicate what decision making restrictions you wish for your property agent:

The powers granted to the property agent shall not be effective unless and until a court at law or my acting physician determines in writing that I am incapable of making decisions due to incapacity or disability. Until such determination is made or upon the removal of such determination, the powers granted to my agent herein shall be not be active and enforceable.

My property agent shall not have the power to change any provisions, beneficiaries, or any beneficiary distributions for life insurance policies, 401K plans, IRAs, pensions, or other existing accounts or plans within my estate or trust that have already been designated by me prior to a court at law or my acting physician's determination that I am incapable of making decisions due to incapacity or disability.

The powers granted to the agent herein shall terminate upon my death.
Please Note: We typically recommend this provision so that there are not competing powers between the property agent and a chosen representative under a Will or Trust.

Additional Property Agent Restrictions:

The powers granted above shall not include the following powers or shall be modified or limited in the following particulars: (NOTE: Here you may include any specific limitations you deem appropriate, such as a prohibition or conditions on the sale of particular stock or real estate or special rules on borrowing by the agent.)

POWER OF ATTORNEY FOR HEALTHCARE

POWER OF ATTORNEY FOR HEALTHCARE: (Who would you want to act as your agent for healthcare decisions during your life if you are unable to do so? Please note that your agent should be at least eighteen (18) years old.)

1st Choice _____
Name Address

Phone: _____ Relationship: _____

2nd Choice _____
Name Address

Phone: _____ Relationship: _____

3rd Choice _____
Name Address

Phone: _____ Relationship: _____

Healthcare Agent Powers

Please indicate below what decision making power you wish to grant to your healthcare agent:

Yes No

If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as my guardian.

Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue, or whole body donation, autopsy, cremation, and burial.

I AUTHORIZE MY AGENT TO: (Please choose Yes for only one of the options below. If no box is checked, or if more than one box is checked, the directive in the first box below shall be implemented.)

Yes No

Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

LIFE-SUSTAINING TREATMENTS:

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

PLEASE SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES:

The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY HEALTHCARE AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically on the lines below:

FINANCIAL STATEMENT

Primary Home

Address: _____

How is it titled? _____

Mortgage Balance: \$ _____

Estimated Current Values

\$ _____

Other Real Estate:

Address: _____

How is it titled? _____

Mortgage Balance: \$ _____

\$ _____

Address: _____

How is it titled? _____

Mortgage Balance: \$ _____

\$ _____

\$ _____

TOTAL

\$ _____

Cash, Bank Accounts, CD's, Treasury Notes, etc.:

Financial Institution: _____ Type of Account: _____

Held Jointly? Yes No If yes, with whom? _____

Payable on Death Designation: _____

\$ _____

Financial Institution: _____ Type of Account: _____

Held Jointly? Yes No If yes, with whom? _____

Payable on Death Designation: _____

\$ _____

Financial Institution: _____ Type of Account: _____

Held Jointly? Yes No If yes, with whom? _____

Payable on Death Designation: _____

\$ _____

TOTAL

\$ _____

Stocks, Bonds, Securities:

Financial Institution: _____ Type of Account: _____

Held Jointly? Yes No If yes, with whom? _____

Payable on Death Designation: _____

\$ _____

Financial Institution: _____ Type of Account: _____

Held Jointly? Yes No If yes, with whom? _____

Payable on Death Designation: _____

\$ _____

Financial Institution: _____ Type of Account: _____

Held Jointly? Yes No If yes, with whom? _____

Payable on Death Designation: _____

\$ _____

TOTAL

\$ _____

FINANCIAL STATEMENT

Life Insurance Death Benefits: Indicate type of insurance policy by the following codes:
 GT-Group Term, IT-Individual Term, W-Whole Life, U-Universal, A-Accidental Death, O-Other.

Company Name: _____ Address: _____
 Policy No. _____ Policy Type: _____ Insured: _____ Owner: _____
 Primary Beneficiary: _____ Contingent Beneficiary(ies): _____
 Cash Value: \$ _____ Loan Amount: \$ _____ Death Benefit: \$ _____

Company Name: _____ Address: _____
 Policy No. _____ Policy Type: _____ Insured: _____ Owner: _____
 Primary Beneficiary: _____ Contingent Beneficiary(ies): _____
 Cash Value: \$ _____ Loan Amount: \$ _____ Death Benefit: \$ _____

Company Name: _____ Address: _____
 Policy No. _____ Policy Type: _____ Insured: _____ Owner: _____
 Primary Beneficiary: _____ Contingent Beneficiary(ies): _____
 Cash Value: \$ _____ Loan Amount: \$ _____ Death Benefit: \$ _____

Vehicles: (Automobiles, Boats, and RVs)

Description	How Titled	Market Value	Loans
\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____

Valuable Personal Property (Ex: Jewelry, Furniture, Antiques, Collections, Paintings, Guns, etc.)

Item	Owner	Market Value
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
Estimated Value of All Other Items Not Listed Above		\$ _____
TOTAL		\$ _____

FINANCIAL STATEMENT

Vested Pension and Profit Sharing Plans, IRA's, Thrift Plan, 401(k) Plans

Company/Plan Name: _____ Address: _____
Account No. _____ Participant: _____ Value: \$ _____
Primary Beneficiary: _____ Contingent Beneficiary(ies): _____

Company/Plan Name: _____ Address: _____
Account No. _____ Participant: _____ Value: \$ _____
Primary Beneficiary: _____ Contingent Beneficiary(ies): _____

Company/Plan Name: _____ Address: _____
Account No. _____ Participant: _____ Value: \$ _____
Primary Beneficiary: _____ Contingent Beneficiary(ies): _____

Company/Plan Name: _____ Address: _____
Account No. _____ Participant: _____ Value: \$ _____
Primary Beneficiary: _____ Contingent Beneficiary(ies): _____

Company/Plan Name: _____ Address: _____
Account No. _____ Participant: _____ Value: \$ _____
Primary Beneficiary: _____ Contingent Beneficiary(ies): _____

Company/Plan Name: _____ Address: _____
Account No. _____ Participant: _____ Value: \$ _____
Primary Beneficiary: _____ Contingent Beneficiary(ies): _____

Company/Plan Name: _____ Address: _____
Account No. _____ Participant: _____ Value: \$ _____
Primary Beneficiary: _____ Contingent Beneficiary(ies): _____

TOTAL \$ _____

Closely-held (not publicly traded) Business Interests

Indicate type of closely held business interest by use of the following codes:

- SC - S Corporation
- CC - Regular C Corporation
- P - Sole Proprietorship
- LLC - Limited Liability Company
- GP - General Partnership
- LP-L - Limited Partnership - Limited Partner Interest
- LP-G - Limited Partnership - General Partner Interest

Please provide us with copies of articles of incorporation, partnership agreements, stockholders agreements, operating agreements or other restrictive agreements which govern transfers of these business interests during life or at death.

Legal Name of Business: _____ Type: _____ Ownership Value: _____
 Business Address: _____ Owner Percentage: _____ %
 Nature of Business: _____
 Number of Other Owners: _____ Other Family Owners? Yes No
 State where Business was created: _____

Legal Name of Business: _____ Type: _____ Ownership Value: _____
 Business Address: _____ Owner Percentage: _____ %
 Nature of Business: _____
 Number of Other Owners: _____ Other Family Owners? Yes No
 State where Business was created: _____

Miscellaneous Interests (Notes, Mortgages, Patents, Trusts, Powers of Appointment, etc.)

Item	Owner	Market Value
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Miscellaneous Debts (Ex: credit cards, personal loans. etc.)

Item	Owner	Market Value
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

TOTAL \$ _____