ESTATE PLANNING QUESTIONNAIRE

(MARRIED OR COUPLE)

Information provided is held in complete confidence, and is used for the sole purpose of analyzing estate planning needs and designing estate planning documents. Preparation of this worksheet is not mandatory prior to the initial appointment with us, but if we are able to review the completed worksheet prior to your appointment, more can generally be covered during the initial consultation.

DURING YOUR INITIAL CONSULTATION, WE WILL DETERMINE YOUR SPECIFIC ESTATE PLANNING NEEDS AND GOALS. THE POTENTIAL COST OF PROBATE AND TAX WHICH WOULD OCCUR WITH YOUR CURRENT ESTATE PLAN WILL BE ANALYZED, AND METHODS OF REDUCING COSTS AND ACCOMPLISHING GOALS WILL BE DISCUSSED. AN EXACT QUOTE ON FEES FOR ESTATE PLANNING WILL BE PROVIDED ***BEFORE*** YOU DECIDE WHETHER YOU WOULD LIKE ANY WORK COMPLETED. IF YOU WOULD LIKE US TO WORK ON YOUR ESTATE PLAN, YOUR INITIAL CONSULTATION FEE WILL BE CREDITED DOLLAR FOR DOLLAR TO THE FLAT FEE COST OF YOUR ESTATE PLAN.

DAVID A. LaRUE, ESQ.,
2021 Sunset Boulevard
Steubenville, OH 43952
PHONE: (740) 284-1000 (Local) or (866) 356-2889 (Toll Free)

ESTATE PLANNING QUESTIONNAIRE
(MARRIED)

Date_____ File Number _____

Home Phone No. _____
Husband's Work Phone No. _____ Wife's Work Phone No. _____
Husband's Cell No. _____ Wife's Cell No. _____
Husband's Beeper No. _____ Wife's Beeper No. _____
E-mail Address _____ Fax No. _____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.

A. PERSONAL DATA

(Husband)
Full Name_____
(print name as shown on your checks)

(Wife)
Full Name _____
(print name as shown on your checks)

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Birth Date _____

Social Security No._____ Social Security No._____

U.S. Citizen? ___ Yes ___ No U.S. Citizen? ___ Yes ___ No

Annual Income_____ Annual Income_____

B. REFERRAL

By whom were you referred to this office?

Name_____

Street Address _____

City_____ State_____ Zip_____

Have you visited our Website? ___ Yes ___ No

Do you have any ideas for improving our Website? If so, please discuss.

_____

_____

C. **CHILDREN** (if applicable)

Child's Name	Address (including zip code)	Date of Birth

Does the Husband have any children by a previous marriage? ___ Yes ___ No

Does the Wife have any children by a previous marriage? ___ Yes ___ No

Are all of your children in good health? ___ Yes ___ No

Are any of your children blind? ___ Yes ___ No

Are any of your children disabled? ___ Yes ___ No

Have all of your children completed their education? ___ Yes ___ No

Are any of your children receiving SSI or other form of government entitlement? ___ Yes ___ No

Do any of your family members have any problems with:

Aids? ___ Yes ___ No
Drug Addiction? ___ Yes ___ No
Alcoholism? ___ Yes ___ No
Spendthrift? ___ Yes ___ No

D. GRANDCHILDREN (if applicable)

Grandchild's Name	Address (including zip code)	Date of Birth

E. DISPOSITIVE INTENTIONS

1. SPOUSE AND CHILDREN

Do you wish to provide primarily for your spouse and secondarily for your children? ___ Yes ___ No

Do you wish to treat all of your children equally? ___ Yes ___ No

If not, why not?_____

After your spouse's death, at what age do you want distribution to your children?_____
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

2. GRANDCHILDREN

Do you want to leave a specific amount of money or a percentage of your estate to your grandchildren?
___ Yes ___ No

Do you wish to treat all of your grandchildren equally? ___ Yes ___ No

If not, why not?_____

How much do you want to leave your grandchildren?_____

At what age do you want distribution to your grandchildren?_____
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

3. CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? ___ Yes ___ No

If yes, please list:

Name of Charity	Address of Charity	Dollar Amount

4. **OTHER BENEFICIARIES**

Do you want your Will to benefit anyone other than children, grandchildren or a charity? ___ Yes ___ No

If so, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

F. EXECUTOR

Whom do you want to serve as your Executor?

(Husband)
First Choice: ___ Spouse ___ Other_____

Second Choice_____

Third Choice_____

(Wife)
First Choice: ___ Spouse ___ Other_____

Second Choice_____

Third Choice_____

G. TRUSTEE

Whom do you want to serve as your Trustee?

(Husband)
First Choice_____

Second Choice_____

(Wife)
First Choice_____

Second Choice_____

H. GUARDIAN

If you have **minor** or **disabled** child/children, whom do you want to act as Guardian?

First Choice_____

Second Choice_____

I. LIVING WILL DECLARATION

(Husband)
Do you want your Living Will Declaration to provide for withdrawal of artificial food and fluid? ___ Yes ___ No

Do you want to donate your eyes or organs? ___ Yes ___ No

Do you want your Health Care Agent to consult with any other person prior to acting? ___ Yes ___ No

If yes, with whom?_____

Name of Proposed Health Care Agent_____

Street Address_____

City_____ State_____ Zip_____

Name of Proposed Alternate Health Care Agent_____

Street Address_____

City_____ State_____ Zip_____

(Wife)
Do you want your Living Will Declaration to provide for withdrawal of artificial food and fluid? ___ Yes ___ No

Do you want to donate your eyes or organs? ___ Yes ___ No

Do you want your Health Care Agent to consult with any other person prior to acting? ___ Yes ___ No

If yes, with whom?_____

Name of Proposed Health Care Agent _____

Street Address _____

City _____ State _____ Zip _____

Name of Proposed Alternate Health Care Agent _____

Street Address _____

City _____ State _____ Zip _____

What are the name and address of each of your primary care physician?

Full Name of Physician _____

Street Address _____

City _____ State _____ Zip _____

J. POWER OF ATTORNEY

(Husband)
Name of Proposed Financial Agent _____

Street Address _____

City _____ State _____ Zip _____

Name of Proposed Alternate Financial Agent _____

Street Address _____

City _____ State _____ Zip _____

(Wife)
Name of Proposed Financial Agent _____

Street Address _____

City _____ State _____ Zip _____

Name of Proposed Alternate Financial Agent _____

Street Address _____

City _____ State _____ Zip _____

K. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? ___ Yes ___ No

If yes, please explain_____

_____

What is the location of your important papers? _____

Do you have a Safe Deposit Box? ___ Yes ___ No

If yes, please indicate the name and address of the location_____

_____

Have you ever made gifts to any one person in excess of $10,000 in any one calendar year?
Yes ___ No ___

Have you ever filed a Federal Gift Tax Return? ___ Yes ___ No

L. FINANCIAL SUMMARY

	ASSETS			LIABILITIES
	Husband	Wife	Joint	
Bank Accounts [attach copies of statements]	$_____	$_____	$_____	$_____
Real Estate (residence) [attach copy of deed or title policy]	$_____	$_____	$_____	$_____
Real Estate (other) [attach copies of all deeds]	$_____	$_____	$_____	$_____
Savings Certificates (CDS) [attach copies of statements]	$_____	$_____	$_____	$_____
Stocks - Non Mutual Funds (Not Held by Broker) [attach copies of all certificates]	$_____	$_____	$_____	$_____
Stocks - Non Mutual Funds (Held by Broker) [attach copies of brokerage statements]	$_____	$_____	$_____	$_____
Bonds - Non Mutual Funds (Not Held by Broker) [attach copies of all bonds]	$_____	$_____	$_____	$_____
Bonds - Non Mutual Funds (Held by Broker) [attach copies of brokerage statements]	$_____	$_____	$_____	$_____
Mutual Funds [attach copies of statements]	$_____	$_____	$_____	$_____
Note and Mortgages Receivables [attach copies of Notes & Mortgages]	$_____	$_____	$_____	$_____
Business Interests [attach copies of stock certificates, partnership agreement and/or other documentation]	$_____	$_____	$_____	$_____
Inheritance, etc.	$_____	$_____	$_____	$_____
Automobiles	$_____	$_____	$_____	$_____
Jewelry & Collections	$_____	$_____	$_____	$_____
Non-IRA Tax Qualified Retirement Plans [attach copies of statements]	$_____	$_____	$_____	$_____
IRAs [attach copies of statements]	$_____	$_____	$_____	$_____
Life Insurance [attach copies of all policies]	$_____	$_____	$_____	$_____
Annuities [attach copies of all policies]	$_____	$_____	$_____	$_____
Other Assets [attach copies of documentation pertaining to such assets]	$_____	$_____	$_____	$_____
TOTALS	$_____	$_____	$_____	$_____

ESSENTIAL ESTATE PLANNING DOCUMENT SYSTEM
OHIO STATUTORY FORMS

1. OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Name of Original Agent: _____

Address: _____

Does Client authorize attending physician to withhold or withdraw any artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, if in a permanently unconscious state or in a terminal condition and the attending physician and one other physician who has determined that such nutrition will not or no longer serve to provide comfort or alleviate pain?

☐ Yes ☐ No

Name of First Alternate Agent _____

Address: _____

Name of Second Alternate Agent _____

Address: _____

Will this Power of Attorney be signed by two witnesses? ☐ Yes ☐ No

2. OHIO LIVING WILL

Does Client authorize attending physician to withhold or withdraw any artificially provided fluid and nutrition, such as by feeding tube or intravenous infusion, if in a permanently unconscious state or terminal condition and the attending physician and one other physician determine that such nutrition will not or no longer serve to provide comfort or alleviate pain?

☐ Yes ☐ No

Does Client wish to use this living will as a DNR ID that will authorize Client's physician, a certified nurse specialist, or a certified nurse practitioner to issue a DNR Comfort Care order?

☐ Yes ☐ No

If yes, list the names and addresses of persons physician should make a good faith effort to notify:

_____

_____

_____

Does Client have a Durable Power of Attorney for Health Care? ☐ Yes ☐ No

Will this Power of Attorney be signed by two witnesses? ☐ Yes ☐ No

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_____

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Personal Residence:

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

Addresses of real property other than personal residence:

(1)Street_____City_____State_____Zip_____

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

(2)Street_____City_____State_____Zip_____

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

M. CERTIFICATION

The undersigned hereby represents to DAVID A. LaRUE, ESQ., P.L.L.C., and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

_____

ESSENTIAL ESTATE PLANNING DOCUMENT SYSTEM
PENNSYLVANIA LIVING WILL

Check all that Client DOES want:
- ☐ Cardiac resuscitation
- ☐ Mechanical respiration
- ☐ Any form of artificial form of nutrition or hydration
- ☐ Blood or blood product
- ☐ Surgery or invasive diagnostic tests
- ☐ Kidney dialysis
- ☐ Antibiotics

Does Client want to name another person to make medical decisions? ☐ Yes ☐ No

If yes: Name of Surrogate: _____

Name of First Alternate Surrogate: _____

Does Client want to make anatomical gifts? ☐ Yes ☐ No

If yes, list limitations on anatomical gifting:

_____

_____

ESSENTIAL ESTATE PLANNING DOCUMENT SYSTEM
PENNSYLVANIA LIVING WILL

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- ☐ Cardiac resuscitation
- ☐ Mechanical respiration
- ☐ Any form of artificial form of nutrition or hydration
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Name of First Alternate Surrogate: _____

Does Client want to make anatomical gifts? ☐ Yes ☐ No

If yes, list limitations on anatomical gifting:

_____

_____