ESTATE PLANNING QUESTIONNAIRE

(SINGLE, WIDOWED, OR DIVORCED PERSON)

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
(SINGLE)

Date _____ File Number _____

Home Phone No. _____ Business Phone No. _____
Cell Phone No. _____ 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

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

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security No. _____

U.S. Citizen? _____ Yes _____ No 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

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

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. CHILDREN

If you have children, do you wish to treat all of your children equally? ____ Yes ____ No

If not, why not? _____

After you 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

If you have grandchildren, do you wish 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? _____

If you have children, do you wish to treat all of your children equally? ____ Yes ____ No

After 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 other than children, grandchildren or a charity? ____ Yes ____ No

If yes, please list: _____

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

F. EXECUTOR

Whom do you wish to serve as your Executor?

First Choice _____

Second Choice _____

G. TRUSTEE

Whom do you wish to serve as your Trustee?

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

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 is the name and address of your primary care Physician?

Full Name of Physician _____

Street Address _____

City _____ State _____ Zip _____

J. POWER OF ATTORNEY

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 $10,000.00 in any one calendar year?

_____ Yes ____ No

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

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

L. FINANCIAL SUMMARY	ASSETS	LIABILITES
Bank Accounts [attach copies of statements]	$_____	$_____
Real Estate (residence) [attach copy of deed or title policy]	$_____	$_____
Real Estate (other) [attach copies of all deeds]	$_____	$_____
Certificate of Deposit (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 statments]	$_____	$_____
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 Mortgage Receivables [attach copies of Notes & Mortgages]	$_____	$_____
Business Interests [attach copies of stock certificates, partnership agreements 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	$_____	$_____

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:

_____