

ESTATE PLANNING QUESTIONNAIRE

These questions pertain to the person named below for whom we are planning. We ask a lot of questions on this form because we need a lot of information about you for our planning for you. Do your best, but don't worry if some of the information you need to complete this form is not available to you.

Date Completed: _____ Referred by: _____

Legal Name: _____

Preferred Name: _____

Aliases (maiden name, legal name change, nick name, etc.)

How do you sign your name on legal documents: _____

Phone Number: _____ Cell: _____

Home Address: _____

County: _____

E-mail address: _____

Date of Birth: _____ Social Security Number: _____

Place of Birth: _____

Do you spend a substantial amount of time in any place other than Tennessee? If so, where?

Are you a U.S. Citizen? Yes No

Are you a veteran? Yes No

What medical or health concerns do you currently have?

What past medical concerns have you had?

Who is your primary care physician?

Name: _____

Address: _____

Phone: _____

Describe your current home:

- Apartment Single Family Home
 Retirement Community Assisted Living Facility
 Other: _____

Do you ever receive assistance with the following activities?

	Never	Sometimes	Often
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Your Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes, please provide the names of the person(s) who provide assistance:

Family Information

Marriage

Name of spouse or significant other (please specify): _____

Date of Birth: _____ Phone Number: _____

Does this person live with you at the address above? Yes No

If no, please list his or her address:

Date of Marriage: _____ Place of Marriage: _____

Have either you or your spouse been married before? Yes No

If yes, please describe any obligations incurred under your or your spouse's divorce decree (ex: alimony, child support, insurance obligations). Attach a copy of the divorce decree, marital dissolution agreement, and any parenting/support orders.

Do you have any dependents (someone who depends on your income/assets for their support)?

Yes No If yes, who? _____

Are any of your children receiving SSI or SSDI?

Yes No If yes, who? _____

Children (please specify if any child is adopted or a stepchild)

(1) Name: _____ Date of Birth: _____
Address: _____ Child of Current Marriage:
_____ Yes No
Phone: _____
Email: _____

(2) Name: _____ Date of Birth: _____
Address: _____ Child of Current Marriage:
_____ Yes No
Phone: _____
Email: _____

(3) Name: _____ Date of Birth: _____
Address: _____ Child of Current Marriage:
_____ Yes No
Phone: _____
Email: _____

(4) Name: _____ Date of Birth: _____
Address: _____ Child of Current Marriage:
_____ Yes No
Phone: _____
Email: _____

Do any of the children listed above have any special personal or financial concerns that should be considered? Ex: physical or mental health concerns, creditor problems, hostility towards other siblings, substance abuse issues, etc.

For any grandchildren to be included in the will, please provide their name, date of birth, current address, and the identity of their parents:

Information About Other Beneficiaries

List the name, address, and phone number of any other person that may be included in this will:

List the names and locations (city, state) of any charitable institutions that may be included in this will:

Appointment of Testamentary Fiduciaries

Please name the person you would like to serve as the Executor/Personal Representative of your estate, as well as an alternate. This is the person who will be responsible for administering your estate and honoring your wishes. They should be trustworthy and a good financial manager.

Executor: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Alternate Executor: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Please name the person you would like to be appointed as **Guardian** of any minor children as well as an alternate Guardian. This is the person who would take physical custody of your minor children if you were unable to care for them.

Guardian: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Alternate Guardian: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

If a trust is to be created for a minor child, please name the person you would like to serve as **Trustee**, as well as an alternate Trustee. This is the person who would manage a minor child's money, until they reach an age that you designate.

Trustee: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Alternate Trustee: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Do you have any pets? If yes, what is your emergency plan for them?

Assets and Liabilities

Do you own any of the following? If so, please describe the approximate value as well as the additional information requested.

Real Estate.

Please provide a copy of the deed. _____

List Any Additional Owner(s): _____

Retirement or pension plan(s).

Provide a copy of latest statement. _____

List Any Additional Owner(s): _____

Partnership or other business interest.

Provide a copy of the Operating Agreement and updated Bylaws. _____

List Any Additional Owner(s): _____

Stocks, bonds, etc.:

Provide copy of latest investment account statement. _____

List Any Additional Owner(s): _____

Savings account(s)/ money market account(s):

Provide latest account statement. _____

List Any Additional Owner(s): _____

Interest in an estate or trust:

Provide copy of trust or will documents. _____

List the Trustee/Executor: _____

Other valuables (ex: art, antiques, etc.): List of documents and approximate value, including any appraisal documents.

_____	_____
_____	_____
_____	_____

Please list any organizations or people to whom you owe money (ex: mortgage, credit cards, student loans):

Fiduciary Documents

If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal and financial affairs? (List in order of priority.)

Attorney-In-Fact: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Alternate Attorney-In-Fact: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Would you want these people (your Attorneys-in-Fact) to be able to make gifts of your property, if they believed that it was necessary for tax reasons or to protect your assets?

- Yes No Don't Know

If yes, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family only, certain charities, etc.)?

- No restrictions, I trust my attorney-in-fact to make the right decision
 My restrictions are: _____

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)?
(List in order of priority)

Health Care Agent Name: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

Alternate Health Care Agent Name: _____

Address: _____

Phone: _____

Email: _____

Relationship to You: _____

If healthcare decisions need to be made on your behalf, do you want your Agent to take your religious preference into account? Yes No

If yes, what religion are you? _____

If you would like an Advanced Care Plan (formerly called a Living Will), please answer the following: Please indicate your wishes concerning organ donation:

- I do not wish to donate my organs.
- I wish to donate any organs which are viable at the time of my death.
- I wish to donate only the following organs:

- I wish to donate my entire body. Preferred organization:

Indicate Your Wishes for Quality of Life: By marking “yes” below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

Yes No

- Permanent unconscious condition:* I become totally unaware of people or surrounding with little chance of ever waking up from the coma.
- Permanent confusion.:* I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- Dependent in All Activities of Daily Living:* I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- End-Stage Illnesses:* I have an illness that has reached its final stages in spite of full treatment. Examples: widespread cancer that does respond anymore to treatment; chronic and/ or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I do not want.

Yes No

- CPR (Cardiopulmonary resuscitation):* To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
- Life support/other artificial support:* Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
- Treatment of new conditions:* Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
- Tube Feeding/IV fluids:* Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Have you made any arrangements for your funeral, for example with a funeral home or at a place of worship? Yes No If so, where?

Do you have any instructions for burial arrangements, hospice care, etc.? Yes No
If so, please describe:

Miscellaneous

Name of Banking Institution(s): _____

Where do you plan to keep the original copy of your will?

Is there any other information that you feel is important when preparing your estate planning documents or that you would like to discuss with the attorney?

Signature: _____ Date: _____

Printed Name: _____