MOSCHELLA & WINSTON, LLP

CLIENT INFORMATION FORM

Referred by: (name & title)

If the person needing services should not be contacted or will not be responding to correspondence from this office, please give us the name and phone number of the Contact Person for the individual in need of services:

Contact Person: ______________________________ Relation: _______________________
Address: ____
Home Phone: _______________________________ Cell: ________________________
Work Phone: _______________________________ Email: ________________________
Would you like to receive our newsletter and other news by email? Yes ____ No ____
Would any other family members be interested in receiving our newsletter and news by email?
Yes ____ No ____ If so, please list email addresses below:
____ ____

PERSONAL DATA (of person(s) needing services) Date questionnaire completed: ____________

Name: ____
First Middle Last

Address: ____

____

Email Address: ____

Day Phone: (______) ________- ____________ Eve. Phone: (______) ________- ____________

Date of Birth (DOB): ________/________/_________ Place of Birth: _________________________

SSN: _____ - _____ - _____ Veteran: YES NO Service Dates (if known): _________________
(may provide at a later date)

Current Medical Status: Check here if additional information on back □

____

____

Spouse: ____
First Middle Last

Date of Birth (DOB): ________/________/_________ Place of Birth: _________________________

SSN: _____ - _____ - _____ Veteran: YES NO Service Dates (if known): _________________
(may provide at a later date)

Date of Marriage: _______ /________/________ Date of Death: ________/________/_________

Current Medical Status: Check here if additional information on back □

____

FAMILY Does the Client have any children? YES NO (Circle Yes or No)
(If yes, please list all children below)

Children:

☐ Male
☐ Female

______________________________ DOB: _______/_______/________
First Middle Last DOD: _______/_______/________

______________________________ Home: (______) _______-________
Address
______________________________ Work: (______) _______-________

Email: ______________________________ Cell: (______) _______-________

____________________ ______________________________
Spouse's Name His/her Children's Names & Ages

☐ Male
☐ Female

______________________________ DOB: _______/_______/________
First Middle Last DOD: _______/_______/________

______________________________ Home: (______) _______-________
Address
______________________________ Work: (______) _______-________

Email: ______________________________ Cell: (______) _______-________

____________________ ______________________________
Spouse's Name His/her Children's Names & Ages

☐ Male
☐ Female

______________________________ DOB: _______/_______/________
First Middle Last DOD: _______/_______/________

______________________________ Home: (______) _______-________
Address
______________________________ Work: (______) _______-________

Email: ______________________________ Cell: (______) _______-________

____________________ ______________________________
Spouse's Name His/her Children's Names & Ages

☐ If there are additional children, please check here and use the same format as above on the back of this page or copy this page and attach it to the questionnaire.

☐ If there are other important relatives or friends involved with this "client", please check here and use the same format as above on the back of this page. Be sure to note how they are related or know the "client".

FAMILY (continued)

Children:

	________________ First Middle Last	DOB: ______/______/______ DOD: ______/______/______
☐ Male ☐ Female	________________ Address ________________	Home: (_____) ______-______ Work: (_____) ______-______
	Email: ________________	Cell: (_____) ______-______
	________ Spouse's Name	________________ His/her Children's Names & Ages

	________________ First Middle Last	DOB: ______/______/______ DOD: ______/______/______
☐ Male ☐ Female	________________ Address ________________	Home: (_____) ______-______ Work: (_____) ______-______
	Email: ________________	Cell: (_____) ______-______
	________ Spouse's Name	________________ His/her Children's Names & Ages

	________________ First Middle Last	DOB: ______/______/______ DOD: ______/______/______
☐ Male ☐ Female	________________ Address ________________	Home: (_____) ______-______ Work: (_____) ______-______
	Email: ________________	Cell: (_____) ______-______
	________ Spouse's Name	________________ His/her Children's Names & Ages

FAMILY (continued) (Circle Yes or No)

Do you or your spouse have any children from a previous marriage? YES NO

Do you or your spouse have children who died leaving children? YES NO

Do you or your spouse have a pre-nuptial/post-nuptial agreement? YES NO

DISABILITY (Circle Yes or No)

Is anyone in your family disabled? YES NO

If yes, who is disabled and what is the nature of the disability?

____

Has anyone in your family recently entered a skilled nursing facility? YES NO

Name of Facility: ____

Address of Facility: ____

____

Admission Date: _____/______/________ Medicare Days End: _____/______/______

Daily Rate: $_______________/day OR Monthly Rate: $__________/month

HEALTH INSURANCE

CLIENT NAME:	______________________ *Client Name*	______________________ *Client Name*
Medicare:	ID #: ________________ Cost per month: ____________	ID #: ________________ Cost per month: ____________
Medicare: Supplement	Company: ________________ ID #: ________________ Cost per month: ____________	Company: ________________ ID #: ________________ Cost per month: ____________
Other:	Company: ________________ ID #: ________________ Cost per month: ____________	Company: ________________ ID #: ________________ Cost per month: ____________
Prescription Plan (if any)	Company: ________________ ID #: ________________ Cost per month: ____________	Company: ________________ ID #: ________________ Cost per month: ____________

(Circle Yes or No)

LIFE INSURANCE **Do you have life insurance? (If YES, complete below)** YES NO

1) Company: ______________________________ Policy #: ______________________________

Owner of policy: ____________________________ Beneficiary: ____________________________

Face Value: ______________________________ Cash Value: ____________________________

2) Company: ______________________________ Policy #: ______________________________

Owner of policy: ____________________________ Beneficiary: ____________________________

Face Value: ______________________________ Cash Value: ____________________________

3) Company: ______________________________ Policy #: ______________________________

Owner of policy: ____________________________ Beneficiary: ____________________________

Face Value: ______________________________ Cash Value: ____________________________

☐ Other Life Insurance policies listed on back of this page in same format.

LONG-TERM CARE INSURANCE

(Circle Yes or No)

Do you have LTC insurance? (If YES, complete below) **YES NO**

Note: this is different from Life Insurance

1) Company: ______________________________ Policy #: ______________________________

Owner of policy: ____________________________

2) Company: ______________________________ Policy #: ______________________________

Owner of policy: ____________________________

3) Company: ______________________________ Policy #: ______________________________

Owner of policy: ____________________________

☐ Other Long-Term Care Insurance policies listed on back of this page in same format.

LIFE INSURANCE (continued)

3) Company: ______________________________ Policy #:_______________________________

Owner of policy:____________________________ Beneficiary:_____________________________

Face Value: ______________________________ Cash Value:_____________________________

4) Company: ______________________________ Policy #:_______________________________

Owner of policy:____________________________ Beneficiary:_____________________________

Face Value: ______________________________ Cash Value:_____________________________

5) Company: ______________________________ Policy #:_______________________________

Owner of policy:____________________________ Beneficiary:_____________________________

Face Value: ______________________________ Cash Value:_____________________________

6) Company: ______________________________ Policy #:_______________________________

Owner of policy:____________________________ Beneficiary:_____________________________

Face Value: ______________________________ Cash Value:_____________________________

LONG-TERM CARE INSURANCE (continued)

4) Company: ______________________________ Policy #:_______________________________

Owner of policy:____________________________

5) Company: ______________________________ Policy #:_______________________________

Owner of policy:____________________________

6) Company: ______________________________ Policy #:_______________________________

Owner of policy:____________________________

FINANCIAL (List all assets, for example, investment, retirement, stocks, bonds, CDs, etc.)

Name of Bank/Institution	Type of Account	Value	Acct. No.***	In Whose Name(s)?
1)________	________	________	________	________
2)________	________	________	________	________
3)________	________	________	________	________
4)________	________	________	________	________
5)________	________	________	________	________
6)________	________	________	________	________
7)________	________	________	________	________

☐ Check here if additional accounts are listed on the back of this page. Use the same format and list starting with 8).

(Circle Yes or No)

Have you or your spouse made any gifts of $1,000.00 or more in the past 3 years? YES NO

If yes, please give explanation of to who the gift was made to, exact amounts, and exact date of gifts on the back of this page.

****Full account numbers are not necessary unless you plan to have this firm assist with Medicaid eligibility, asset management, or fiduciary services. Last four digits of the account number will suffice in most cases to avoid confusion in describing accounts.*

REAL ESTATE

	Property #1	Property #2
Property Address		
Purchase Price	$	$
Purchase Date		
Assessed Value	$	$
Current Value	$	$
Current Owners on Deed		

FINANCIAL (continued)

Name of Bank/Institution	Type of Account	Value	Acct. No.***	In Whose Name(s)?
8)				
9)				
10)				
11)				
12)				
13)				
14)				

GIFTS (continued)

Gift Given to:	Amount	Date given	From Account:
1)			
2)			
3)			
4)			
5)			

MONTHLY GROSS INCOME

CLIENT NAME:	________________	________________
	Client Name	*Client Name*
Social Security	$________________/month	$________________/month
Pension	$________________/month	$________________/month
Annuity	$________________/month	$________________/month
Veteran's Benefits	$________________/month	$________________/month
Rent	$________________/month	$________________/month
Other:________________	$________________/month	$________________/month

☐ Check here if additional info listed on back of this page.

LIABILITIES (Mortgages, notes to banks, loans, credit cards, etc.)

Description	Balance	Monthly Payment	Maturity Date
________________	________________	________________	______________
________________	________________	________________	______________

☐ Check here if additional info listed on back of this page.

MONTHLY EXPENSES

Rent/Mortgage: $________________/month
Property Taxes: $________________/month
Home Insurance: $________________/month
Electric/Gas: $________________/month
Water/Sewer: $________________/month
Health Ins. Premium $________________/month
Prescriptions: $________________/month

AUTOMOBILE

(Circle Yes or No)

Do you own a Car? YES NO
Make/Model/Year: ______________
Car Insurance cost: $______________
Car Fair Market Value: $______________

Other (please explain): ____
____

Total Monthly Expenses: $____________________

OTHER

Last fiscal year you filed tax returns? __________

If you did not prepare them, who did?
Name: ____
Address: ____
____
Telephone: __________________________ Fax: ______________________________

If you have had previous estate planning work done, who was your attorney?
Name: ____
Address: ____
____
Telephone: __________________________ Fax: ______________________________

ESTATE PLANNING
(If you answer yes to any of the following, please bring copies with you to your meeting)

CLIENT NAME:	______________________ *Client Name*	______________________ *Client Name*
	(Circle Yes or No)	(Circle Yes or No)
Last Will & Testament	YES/NO Date signed: ______	YES/NO Date signed: ______
Durable Power of Attorney	YES/NO Date signed: ______	YES/NO Date signed: ______
Health Care Proxy	YES/NO Date signed: ______	YES/NO Date signed: ______
Revocable Trust	YES/NO Date signed: ______	YES/NO Date signed: ______
Irrevocable Trust	YES/NO Date signed: ______	YES/NO Date signed: ______
Guardianship or Conservatorship of you	YES/NO Date signed: ______	YES/NO Date signed: ______
Who is your Guardian?	_________________________	_________________________
Guardian or Conservator of another?	YES/NO Date signed: ______	YES/NO Date signed: ______
Who are you Guardian of?	_______________________	_________________________
Executor of an estate	YES/NO	YES/NO
Whose estate?	___________________________	___________________________

	(Circle Yes or No)	(Circle Yes or No)
Do you have pre-paid funeral contracts?	YES/NO	YES/NO

If yes, with what company? ____

Do you have a burial account?	YES/NO	YES/NO

If yes, with what bank? ____

WHAT TO BRING TO FIRST MEETING:

*** Important especially if you will be discussing Medicaid planning or application

- ☐ Wills and codicils
- ☐ Trusts
- ☐ Real estate documents (deed)
- ☐ Guardianship documents
- ☐ Health Care Proxies/Living Wills
- ☐ Durable Powers of Attorney
- ☐ Annuity information ***
- ☐ Pre-paid funeral contracts or burial accounts ***
- ☐ Life insurance policies ***
- ☐ Long-Term Care insurance policies ***
- ☐ Copy of latest bank/stock statements and all passbooks ***
- ☐ Death certificate (if applicable)
- ☐ Latest income check stubs (or latest bank statements into which direct deposits go) ***
- ☐ Questions you would like reviewed
- ☐ This questionnaire filled out as completely as possible ***

YOUR QUESTIONS:

____

____

____

____

____

____

THANK YOU!

Thank you for taking the time to complete this questionnaire.
The reason we have our clients bring this information to the first meeting is to assist us in giving you the most accurate recommendations based on the information you provide.
As a result, you will get the most out of your first meeting.
We look forward to meeting you!

The Attorneys & Staff at:
MOSCHELLA & WINSTON, LLP

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