
CONFIDENTIAL

ELDERCARE PLANNING PERSONAL INFORMATION QUESTIONNAIRE

The purpose of this Personal Information Questionnaire is to help prepare for our upcoming consultation. This preparation provides us with important personal and family information about the person in need of care, their family and their trusted advisors. The last page of this questionnaire asks for an estimated value of the estate assets. Complete answers will help enable us to most effectively advise you.

It will be very helpful if you can complete and return this Personal Information Questionnaire to our office prior to our initial consultation meeting.

LAW OFFICES OF
THE MALL MALISOW FIRM, P.C.
HOLISTIC ESTATE & ELDERCARE ATTORNEYS
30445 NORTHWESTERN HWY, SUITE 250
FARMINGTON HILLS, MICHIGAN 48334
PHONE (248) 538-1800 FACSIMILE (248) 538-1801
(866) 699-1800 TOLL FREE

PERSONAL INFORMATION

(Please Print)

Person in Need of Care

Date Completed _____

Full Legal Name _____

Print their name as it is signed on legal documents _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ County of Residence _____

Employer _____ Position _____ Business Telephone (____) _____

Business address _____ City _____ State _____ Zip _____

Married: _____ Divorced: Date _____ Widowed: Date _____ Single

U.S. Citizen Lived in the following states: CA, WA, NV, AZ, NM, TX, ID, LA or WI

Spouse

Name _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Business Telephone (____) _____

Person Seeking Legal Counsel

Name _____ Relationship _____

Home address _____ City _____ State _____ Zip _____

Home Telephone (____) _____ Business Telephone (____) _____

CHILDREN'S INFORMATION

Child # 1

Child's Full Legal Name _____ Male Female

Name of Parent(s) of Child #1: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special Needs
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 2

Child's Full Legal Name _____ Male Female

Name of Parent(s) of Child #2: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special Needs
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 3

Child's Full Legal Name _____ Male Female

Name of Parent(s) of Child #3: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special Needs
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 4

Child's Full Legal Name _____ Male Female

Name of Parent(s) of Child #4: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special Needs
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 5

Child's Full Legal Name _____ Male Female

Name of Parent(s) of Child #5: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special Needs
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Child # 6

Child's Full Legal Name _____ Male Female

Name of Parent(s) of Child #6: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs: Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Grandchildren's Names	Parents	Ages	Special Needs
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

OTHER DEPENDENTS

Friends or relatives who are dependents.

Dependent # 1

Dependent's Full Legal Name _____

Relationship: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

Dependent # 2

Dependent's Full Legal Name _____

Relationship: _____

Nickname _____ Birth date _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone _____ County of Residence _____

Employer _____ Occupation _____ Education _____

Business address _____ City _____ State _____ Zip _____

Special Needs Medical Educational Financial

Married Divorced Widowed Single Spouse's Name: _____

CARE STATUS

What is the diagnosis? _____

Is the person in need of care competent to express his/her wishes? Yes _____ No _____

Who is providing care now? _____

How is care being paid for? _____

If known, what does person in need of care want to have happen now ? _____

How and where is that documented? _____

What does family want? (Note if there are conflicts) _____

Please provide the following information / documentation:

Copy of assessment, care plan, recent medical reports (if available).

Copy of contact information for all medical and care providers.

Copies of **all** estate planning documents (if available):

Will, Trust, Durable Power of Attorney, Patient Advocate Designation (Living Will).

Copies of Court documents **if** Guardian and/or Conservator appointed.

IMPORTANT FAMILY QUESTIONS

Please Check "Yes" or "No" for Your Answer	YES	NO
Does person in need of care have a child with a learning disability?		
Does person in need of care have a child who receives governmental support or benefits?		
Do any of their children have special education, medical, or physical needs?		
Are any of their children institutionalized?		
Is person in need of care or their spouse receiving social security, disability, or other governmental benefits?		
Does person in need of care provide primary or other major financial support to adult children?		
Is person in need of care making payments pursuant to a divorce or property settlement agreement? (Please furnish a copy.)		
Has person in need of care signed a pre- and/or post- marriage contract? (Please furnish a copy.)		
Has person in need of care or their spouse ever filed Federal or State gift tax returns? (Please furnish a copy.)		
Has person in need of care completed Health Care Powers of Attorney or Living Wills? (Please furnish copies.)		
Has person in need of care completed wills, trusts, or estate planning? (Please furnish copies.)		
Is person in need of care a United States citizen?		
If you answered "NO," is he or she a resident or a non-resident alien?		

OTHER PROFESSIONAL ADVISORS

Name of CPA: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Financial Advisor: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Family Attorney: _____

Law Firm _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Stock Broker: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Life Insurance Agent: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Name of Personal Banker: _____

Company _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Fax # _____ E-Mail: _____

Estimated Asset Valuation Sheet For Person in Need of Care

ASSETS*	<i>AMOUNT</i>		
	Joint	His	Hers
Cash Accounts			
Investment Accounts			
Stocks			
Automobiles and Recreational Vehicles			
Retirements Plans			
Pension Plans			
Life Insurance Policies			
Annuities			
Bonds			
Monies Owed to You			
Homestead			
Other Real Property			
Oil, Gas, and Mineral Interests			
Business Interests: (S Corp, LLC, Partnership)			
Sole Proprietorship Interests			
Anticipated Inheritance, Gift, or Judgment			
Pre-Paid Funeral/Burial Costs/Plots			
Other Assets			
TOTAL ASSETS			
LIABILITIES			
	<i>AMOUNT</i>		
Loans payable			
Accounts payable			
Real estate mortgages payable			
Loans against life insurance			
Unpaid taxes			
Other obligations			
TOTAL LIABILITIES			
NET ESTATE			
MONTHLY INCOME			
	His	Hers	
Social Security, pension, other regular income			