
CONFIDENTIAL

SPECIAL NEEDS 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
(248) 538-1800 (248) 538-1801 FACSIMILE
(866) 699-1800 TOLL FREE

PERSONAL INFORMATION

(Please Print)

Person in Need of Services

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 _____

Home address _____ City _____ State _____ Zip _____

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

Person Seeking Legal Counsel

Name _____ Relationship _____

Home address _____ City _____ State _____ Zip _____

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

FAMILY INFORMATION

(This includes parents, children, siblings and others caring for SN Individual)

Individual #1: Full Legal Name _____ Male Female
Nickname _____ Birth date _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home telephone _____ Work telephone _____ County of Residence _____
 Married Divorced Widowed Single Spouse's Name: _____

Individual #2: Full Legal Name _____ Male Female
Nickname _____ Birth date _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home telephone _____ Work telephone _____ County of Residence _____
 Married Divorced Widowed Single Spouse's Name: _____

Individual #3: Full Legal Name _____ Male Female
Nickname _____ Birth date _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home telephone _____ Work telephone _____ County of Residence _____
 Married Divorced Widowed Single Spouse's Name: _____

Individual #4: Full Legal Name _____ Male Female
Nickname _____ Birth date _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home telephone _____ Work telephone _____ County of Residence _____
 Married Divorced Widowed Single Spouse's Name: _____

Individual #5: Full Legal Name _____ Male Female
Nickname _____ Birth date _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home telephone _____ Work telephone _____ County of Residence _____
 Married Divorced Widowed Single Spouse's Name: _____

Please include other individuals on the back or an additional sheet as necessary.

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 needing services have a child with learning disability? | | |
| Does person needing services 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 services or their spouse receiving social security, disability, or other governmental benefits? | | |
| Does person in need of services provide primary or other major financial support to adult children? | | |
| Is person in need of services making payments pursuant to a divorce or property settlement agreement? (Please furnish a copy.) | | |
| Has person in need of services 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 services completed Health Care Powers of Attorney or Living Wills? (Please furnish copies.) | | |
| Has person in need of services completed wills, trusts, or estate planning? (Please furnish copies.) | | |
| Is person in need of services a United States citizen? | | |
| If you answered "NO," is he or she a resident or a non-resident alien? | | |

Government Benefits

Medicaid YES NO CASE # _____

Medicare YES NO CASE# _____

SSI YES NO

SSDI YES NO

For all benefits checked "YES"- Please provide a copy of Medicaid and/or Medicare card, or evidence of SSI or SSDI payment if applicable.

Medicaid (Family Independence Agency) Information

Name of caseworker assigned to file: _____

Address of FIA office: _____

Telephone Number: _____

Please provide a copy of recent communications from FIA (i.e., approval letter, verification request, etc...) including a copy of information submitted to FIA (annual account, etc...)

Community Mental Health Information

Name of worker assigned to file: _____

Address of CMH office: _____

Telephone number: _____

Please provide a copy of recent communications from CMH (i.e., person centered plan)

Social Security Information

Name of caseworker assigned to file: _____

Office Address: _____

Telephone Number: _____

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> | |
|--|----------------------|--------------|
| | Individual | Joint |
| 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 | |
| Social Security, pension, other regular income | |