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CONFIDENTIAL

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ELDERCARE PLANNING  
PERSONAL INFORMATION  
QUESTIONNAIRE

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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.

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LAW OFFICES OF  
**MALL MALISOW & COONEY, P.C.**  
HOLISTIC ESTATE & ELDERCARE ATTORNEYS  
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FARMINGTON HILLS, MICHIGAN 48334  
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(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

Served in Military:  Yes  No Dates Served: \_\_\_\_\_

## Spouse

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Birth date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Military Service:  Yes  No Dates: \_\_\_\_\_

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: \_\_\_\_\_

Military Service:  Yes  No Dates: \_\_\_\_\_

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: \_\_\_\_\_

Military Service:  Yes  No Dates: \_\_\_\_\_

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: \_\_\_\_\_

Military Service:  Yes  No Dates: \_\_\_\_\_

<b>Grandchildren's Names</b>	<b>Parents</b>	<b>Ages</b>	<b>Special Needs</b>
_____	_____	_____	<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: \_\_\_\_\_

Military Service:  Yes  No Dates: \_\_\_\_\_

<b>Grandchildren's Names</b>	<b>Parents</b>	<b>Ages</b>	<b>Special Needs</b>
_____	_____	_____	<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: \_\_\_\_\_

Military Service:  Yes  No Dates: \_\_\_\_\_

<b>Grandchildren's Names</b>	<b>Parents</b>	<b>Ages</b>	<b>Special Needs</b>
_____	_____	_____	<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: \_\_\_\_\_

Military Service:  Yes  No Dates: \_\_\_\_\_

<b>Grandchildren's Names</b>	<b>Parents</b>	<b>Ages</b>	<b>Special Needs</b>
_____	_____	_____	<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: \_\_\_\_\_

Military Service:  Yes  No Date: \_\_\_\_\_

## **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: \_\_\_\_\_

Military Service:  Yes  No Date: \_\_\_\_\_

# 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

<b>ASSETS*</b>	<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			
<b>TOTAL ASSETS</b>			
<b>LIABILITIES</b>	<i>AMOUNT</i>		
Loans payable			
Accounts payable			
Real estate mortgages payable			
Loans against life insurance			
Unpaid taxes			
Other obligations			
<b>TOTAL LIABILITIES</b>			
<b>NET ESTATE</b>			
<b>MONTHLY INCOME</b>			
Social Security, pension, other regular income	His	Hers	