

**ASSET PROTECTION PLANNING QUESTIONNAIRE  
(SINGLE)**

Date \_\_\_\_\_ File No. \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

**This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to our initial appointment.**

**A. PERSONAL DATA**

Full Name \_\_\_\_\_  
(print full legal name)

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

U.S. Citizen? Yes  No  Veteran? Yes  No

If widowed, please list name of spouse and date of death \_\_\_\_\_

Was your former spouse a Veteran? Yes  No

**B. MEDICAL DATA**

**1. HEALTH**

Diagnosis \_\_\_\_\_

Prognosis \_\_\_\_\_

**2. PHYSICIAN**

Full Name of Primary Physician \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**3. STATE PHARMACEUTICAL PLAN**

Are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or any other state pharmaceutical plan?      Yes       No

**C. MONTHLY INCOME**

Social Security Benefits (include \$115.40 Medicare Part B Deduction, if applicable)      \$ \_\_\_\_\_

Retirement Benefits (Gross)      \$ \_\_\_\_\_

Veterans Disability Income      \$ \_\_\_\_\_

Annuity Income      \$ \_\_\_\_\_

Rental Income      \$ \_\_\_\_\_

**TOTAL MONTHLY INCOME**      \$ \_\_\_\_\_

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future?    Yes       No

Do not include interest and dividend income on this form.

**D. LAST WILL AND TESTAMENT  
DISPOSITIVE INTENTIONS - CHILDREN**

Child's Name	Address (including zip code)	Date of Birth

If you have children, do you wish to treat all of your children equally?      \_\_\_ Yes      \_\_\_ No

If not, why? \_\_\_\_\_

After your death, at what age do you want distributions to be made to your children? \_\_\_\_\_  
 (e.g. typical plans provide for immediate distributions or for 1/3 at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35)

Are all of your children in good health?  Yes  No

Are any of your children disabled?  Yes  No

Are any of your children receiving SSI or other form of government benefits?  Yes  No

Do any of your family members have any problems with:

Creditors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Addiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spendthrift?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**GRANDCHILDREN**

If you have grandchildren, do you wish to leave a specific amount of money or a percentage of your estate to your grandchildren?  Yes  No

If yes, please list:

Grandchild's Name	Address (including zip code)	Date of Birth

Do you wish to treat all of your grandchildren equally?  Yes  No

If not, why? \_\_\_\_\_

How much do you want to leave your grandchildren? \_\_\_\_\_

At what age do you want distributions to your grandchildren? \_\_\_\_\_  
 (e.g., typical plans provide for immediate distributions or for 1/3 at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35)



**F. LIVING WILL**

Do you want a Living Will?  Yes  No

Do you want your Living Will to provide for withdrawal of artificial food and fluid?  Yes  No

Do you want to donate your eyes or organs?  Yes  No

Whom do you want to make your medical decisions?

First Choice \_\_\_\_\_  
(Name) (Address)

Second Choice \_\_\_\_\_  
(Name) (Address)

Do you want the person making your medical decisions to consult with any other person prior to acting?  
 Yes  No

If yes, with whom? \_\_\_\_\_

What are the name and address of your primary care physician?

Full Name of Physician \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**G. ASSETS/LIABILITIES**

Please insert the value of each asset/liability in the appropriate space.

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ (Obtain from Tax Bill)		
OTHER REAL ESTATE		
AUTOMOBILE(S)		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
IRA		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
<b>TOTAL</b>		

**What did you pay for your current home including any improvements? \$ \_\_\_\_\_**

Address of any real property other than personal residence:

(1) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tax Block # \_\_\_\_\_, Lot # \_\_\_\_\_ (Can be obtained from Tax Bill)

**What did you pay for this property including any improvements? \$ \_\_\_\_\_**

(2) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tax Block # \_\_\_\_\_, Lot # \_\_\_\_\_ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ \_\_\_\_\_

Name of Homeowner's Insurance Company \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Policy No \_\_\_\_\_

**H. GIFTS**

Have you made any gifts, to an individual or group of individuals, or to a trust within the past 60 months?  
Yes  No

If yes, list below:

Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____

Have you ever filed a Federal Gift Tax Return? Yes  No

If so, please state details \_\_\_\_\_

**I. LIFE INSURANCE**

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

**J. MISCELLANEOUS**

Do you have any other legal issues which I should be aware of: Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**K. REFERRAL**

By Whom Were You Referred To This Office?

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Have you visited our Website?      Yes       No

Do you have any ideas for improving our Website? If so, please discuss.

\_\_\_\_\_  
\_\_\_\_\_

**L. CERTIFICATION**

The undersigned hereby represents to Fendrick & Morgan, LLC, that the information contained in this intake form is accurate and complete. The undersigned is aware that the law firm will rely on this information and further understands that the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

\_\_\_\_\_