

CRISIS/ BENEFITS QUESTIONNAIRE

INSTRUCTIONS: Please complete this form as best you can with the information pertinent to the person for whom benefits are sought (the client). When you come in for your initial appointment, please bring as many of the items/documents identified in this questionnaire as possible. It is very important that the client's information requested in the questionnaire is completed, as this allows the Firm to better understanding of the client's situation.

PART I: PERSONAL INFORMATION

If possible, please use *full legal names* (first, full middle and last) when asked for names.

Client: (person for whom benefits / information is needed)

Name: _____

Birth date: _____ SSN: _____ Nickname: _____

If not a US Citizen, what is your citizenship? _____

Are you a veteran? Yes No If yes, dates of active duty and branch: _____

Honorable Discharge? Yes _____ No _____ If No, please provide: _____

Where is Client currently residing (if different): (Name of Facility) _____

Address: _____

Phone: _____ Name of Social Worker: _____

Spouse: (If applicable)

Name: _____

Birth date: _____ SSN: _____ Nickname: _____

If not a US Citizen, what is spouse's citizenship? _____

Is spouse a veteran? Yes No If yes, dates of active duty and branch: _____

Honorable Discharge? Yes _____ No _____ If No, please provide: _____

Please provide the DD214 (discharge paperwork) for veteran.

Name of Person Completing this Questionnaire, **if not client:**

Name: _____

Relationship to Clients: _____

Are you a legally appointed agent under a POWER OF ATTORNEY or TRUST for the person for whom you are completing this form? Yes _____ No _____

Address: _____

Phone: _____ Email: _____

GOAL: Please describe in your own words what you would like for our office to accomplish for you/client?

Client's Marital Status

Married Single Divorced Widowed Life Partnership

If Married: Date of Marriage: _____ State where Married: _____

If Divorced: Date of Divorce: _____ Length of Marriage: _____

PART II: FAMILY INFORMATION

Client's Children:

Please note that "full name" includes full middle name. Please write "dec" after child's name if that child is deceased.

Oldest child *full* name: _____ Nickname: _____

SSN: _____ Birth date: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Related to: Both Husband Wife Child's Spouse's name: _____

First names of children: _____

Is this child dependent upon you? Yes No Does this child live with you? Yes No

Next child *full* name: _____ Nickname: _____

SSN: _____ Birth date: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Related to: Both Husband Wife Child's Spouse's name: _____

First names of children: _____

Is this child dependent upon you? Yes No Does this child live with you? Yes No

Next child *full* name: _____ Nickname: _____

SSN: _____ Birth date: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Related to: Both Husband Wife Child's Spouse's name: _____

First names of children: _____

Is this child dependent upon you? Yes No Does this child live with you? Yes No

Next child *full* name: _____ Nickname: _____

SSN: _____ Birth date: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Related to: Both Husband Wife Child's Spouse's name: _____

First names of children: _____

Is this child dependent upon you? Yes No Does this child live with you? Yes No

For additional children, please use the last page of the Questionnaire

Does a dependent or family member have special educational, medical or financial needs? Yes No

If Yes, please explain: _____

If any family member is deceased, please write "dec" after his or her name.

Part III: Financial Information

MONTHLY INCOME

	Client	Spouse
Salary:	\$ _____	\$ _____
Pension:	\$ _____	\$ _____
Annuities:	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
SSI:	\$ _____	\$ _____
Investment Income	\$ _____	\$ _____
Interest Income:	\$ _____	\$ _____
Other:	\$ _____	\$ _____
Total monthly	\$ _____	\$ _____

Please bring copy of income statements for all income identified above to the meeting.

Health Care Expenses

How Much?

Medical (to extent not reimbursed by insurance)

Nursing home fees

Assisted Living Rent

Medical insurance

Physician services

Optometrist fees

Dental treatment

Psychological counseling

Physical therapy

Occupational therapy

Home health aides

Visiting nurses

Personal care services

Eyeglasses

Hearing aids

Prescription medicines

Nonprescription medicines

Medical appliances

Other:

Has the Client recently entered a hospital? If Yes, date: _____

Name of Facility: _____

Address of Facility: _____

Date of Admission: _____ Date of Discharge: _____

Where did the Client go from the hospital? _____

Medical Diagnosis: _____

Amount still owed after insurance/Medicare? \$ _____

Date through which care is/was covered by Medicare: _____

Any prior admissions into a skilled nursing facility (Nursing home)? No ____ Yes ____

Name of Facility: _____

Address of Facility: _____

Date of Admission: _____ Date of Discharge: _____

Where did the Client go from the hospital? _____

Medical Diagnosis: _____

Amount still owed after insurance/Medicare? \$ _____

Date through which care is/was covered by Medicare: _____

Medical Insurance:

Supplemental Insurance through (name of company): _____

Medicare Part D: Yes ____ No ____

Service connected insurance (Tricare): Yes ____ No ____

PROPERTY

Please list all assets you own at fair market value (estimates are OK)

Home: \$ _____ Is there a mortgage on this property? No Yes, balance: \$ _____

Other Real Estate: \$ _____ (Number of parcels _____)

Is there a mortgage on this real estate? no yes , balance: \$ _____

Checking, Savings, CDs, Money Markets, etc.

Name of Institution	Value in Account	Last 4 of account #	Ownership Status

Non-qualified Assets, including Investments, Bonds, Stocks, Annuities, Mutual Funds, etc.

Name of Institution	Value in Account	Last 4 of account #	Ownership Status

Qualified Accounts, including IRAs, Roth IRAs, SEP, 401K, VIP, Deferred Comp, etc.

Name of Institution	Value in Account	Last 4 of account #	Ownership Status

Life Insurance Plans/Policies:

Name of Insurance Provider	Name of Insured	Cash Value	Death benefit	Death beneficiary

Vehicles, RVs, ATVs, Boats, other:

Type of Vehicle	Current Value	Debt Associated	Ownership Status

Any Business interests/ownership, LLC, LLP, LP, S-Corp, etc:

Name of business	Value of ownership	Ownership Status	Death Beneficiary

Please bring statements for all accounts identified above to the meeting.

Any personal property valued over \$10,000? If so, please describe: _____

Any pre-paid burial or funeral arrangements? No _____ Yes _____

If yes, please bring policies for services to the meeting.

CURRENT PLANNING

Please place a checkmark beside each document that Client currently has:

- | | |
|---|---|
| <input type="checkbox"/> Will | <input type="checkbox"/> Revocable Living Trust |
| <input type="checkbox"/> Community Property Agreement | <input type="checkbox"/> Written Financial Plan (Please bring in) |
| <input type="checkbox"/> Prenuptial Agreement | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Durable Power of Attorney | _____ |
| <input type="checkbox"/> Health Care Power of Attorney | |
| <input type="checkbox"/> Living Will | |
| <input type="checkbox"/> Irrevocable Trust(s) Please explain: | |

Please bring along to the meeting any of the legal documents identified above.

ADVISORS

Primary Care Physician

Accountant

Name: _____
Practice: _____
Address: _____
City, State Zip: _____
Phone: _____
Fax: _____
E-mail: _____

Insurance Agent

Financial Planner

Name: _____
Firm: _____
Address: _____
City, State Zip: _____
Phone: _____
Fax: _____
E-mail: _____

Does client have long term care insurance? No _____ Yes _____

If yes, please bring policy to the meeting.

Has client gifted \$500 or more during the past five years? Yes ____ No ____

If yes, please describe: _____

Has client sold or traded anything in the past five years? Yes ____ No ____

If yes, please describe: _____

Who referred you to our firm? _____