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"CONFIDENTIAL QUESTIONNAIRE"

Please fill out completely and fax or mail back. This form is **extremely important**. Your accuracy and completeness in responding will help me best represent you. All sections and information must be filled out prior to sitting down with the attorney. **Bring this information with you to your appointment.**

Please be sure to check all appropriate boxes. If "NONE", please state "NONE". If "NOT APPLICABLE", please state "N/A".
FOR EXAMPLE IF YOUR SPOUSE IS DECEASED ANSWER "N/A"
PLEASE PRINT CLEARLY

PLANNING QUESTIONNAIRE

Date_____ File No. _____

Home Phone No._____ Business Phone No._____

Cell Phone No._____ Fax No._____

E-mail Address _____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to your appointment.

A. CLIENT DATA

If widowed, please list name of spouse and date of death _____

IF YOUR SPOUSE IS DECEASED ANSWER "N/A"BELOW

(Husband)
Full Name_____
(print name as shown on your checks)

(Wife)
Full Name _____
(print name as shown on your checks)

Street Address _____

City_____ State_____ Zip _____

(Husband)
Birth Date_____

(Wife)
Birth Date _____

Social Security No._____

Social Security No. _____

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

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

If you or your spouse is a Veteran, are you receiving Tricare? Q Yes Q No

B. MEDICAL DATA

1. HEALTH

HUSBAND (MALE)

Do you suffer from any medical conditions_____?

Diagnosis _____

Name of Nursing Home _____

Date Entered _____

WIFE (FEMALE)

Do you suffer from any medical conditions_____?

Diagnosis _____

Name of Nursing Home _____

Date Entered _____

2. PHYSICIANS

Full Name of Husband's Primary Physician
_____

Street Address _____

City_____ State_____ Zip _____

Full Name of Wife's Primary Physician

_____

Street Address _____

City_____ State_____ Zip _____

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (include $ Medicare Part B Deduction, if applicable)	$_____	$_____
Pension/Retirement Benefits (Gross)	$_____	$_____
Employment	$_____	$_____
Veterans Disability Income	$_____	$_____
Annuity Income	$_____	$_____
Rental Income	$_____	$_____
Other _____	$_____	$_____
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.

Do not include interest and dividend income on this form.

D. MONTHLY SHELTER EXPENSES
(Please divide annual expenses by 12 and quarterly expenses by 4)

Rent/Mortgage	$_____
Real Estate Taxes	$_____
Water	$_____
Sewer	$_____
Utilities (Heat, Electric & Telephone) (1/12th of last 12 months)	$_____

Homeowner=s insurance premium $_____

Condominium fees $_____

Total Monthly Housing Expenses $_____

E. MONTHLY NON-SHELTER LIVING EXPENSES

Food $_____

Medical $_____

Clothing $_____

Transportation (including auto insurance) $_____

Home Maintenance $_____

Life Insurance Premiums $_____

Health Insurance Premiums $_____

Cable TV $_____

Federal and State Income Taxes $_____

Other $_____

Total Monthly Non-Shelter Living Expenses $_____

If applicable: **MONTHLY COST OF NURSING HOME**

Monthly Nursing Home Cost $_____

Monthly Prescription Cost $_____

Monthly Incontinent Cost $_____

Monthly Medical Insurance Cost (Ill Spouse Only) $_____

Monthly Other Cost $_____

Total Monthly Cost $_____

F. GIFTS

Have you made any gifts within the last five years to an individual or to a trust? Q Yes Q No

If yes, list below:

Recipient_____ Date _____ Amount_____

Recipient_____ Date _____ Amount_____

Recipient_____ Date _____ Amount_____

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

If yes, `please state details _____

_____

_____

G. CHILDREN (if applicable, include adult and minor children)

Name of Child 1_____ Gender: Q Male Q Female

Street Address _____

City_____ State_____ Zip _____

Home Phone Number_____ Work Phone Number _____

Date of Birth_____ Social Security Number _____

E-mail Address _____

Relationship to Husband: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock
Relationship to Wife: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock

Name of Child 2_____ Gender: Q Male Q Female

Street Address _____

City_____ State_____ Zip _____

Home Phone Number_____ Work Phone Number _____

Date of Birth_____ Social Security Number _____

E-mail Address _____

Relationship to Husband: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock
Relationship to Wife: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock

Name of Child 3_____ Gender: Q Male Q Female

Street Address _____

City_____ State_____ Zip _____

Home Phone Number_____ Work Phone Number _____

Date of Birth_____ Social Security Number _____

E-mail Address _____

Relationship to Husband: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock
Relationship to Wife: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock

Name of Child 4_____ Gender: Q Male Q Female

Street Address _____

City_____ State_____ Zip _____

Home Phone Number_____ Work Phone Number _____

Date of Birth_____ Social Security Number _____

E-mail Address _____

Relationship to Husband: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock
Relationship to Wife: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock

Name of Child 5_____ Gender: Q Male Q Female

Street Address _____

City_____ State_____ Zip _____

Home Phone Number_____ Work Phone Number _____

Date of Birth_____ Social Security Number _____

E-mail Address _____

Relationship to Husband: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock
Relationship to Wife: Q Natural child Q Adopted Q Stepchild Q Child born out of wedlock

Are all of your children in good health? Q Yes Q No

Are any of your children blind? Q Yes Q No

Are any of your children disabled? Q Yes Q No

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

If yes: How much is the child=s monthly payment? $_____

Is the child receiving Medicaid or Medicare? Q Medicare Q Medicaid

Do any of your family members have any problems with:

AIDS?	Q Yes	Q No
Drug Addiction?	Q Yes	Q No
Alcoholism?	Q Yes	Q No
Spendthrift?	Q Yes	Q No

Do any of your children live with you in your home? Q Yes Q No

If yes, name of child _____

Are you a contributor to a 529 Plan? Q Yes Q No

If yes, please attach a statement of the 529 account.

H. GRANDCHILDREN

Name of Grandchild 1 _____ Gender: Q Male Q Female

Relationship to Husband: Q Natural grandchild Q Stepgrandchild
Relationship to Wife: Q Natural grandchild Q Stepgrandchild

Name of Grandchild 2 _____ Gender: Q Male Q Female

Relationship to Husband: Q Natural grandchild Q Stepgrandchild
Relationship to Wife: Q Natural grandchild Q Stepgrandchild

Name of Grandchild 3 _____ Gender: Q Male Q Female

Relationship to Husband: Q Natural grandchild Q Stepgrandchild
Relationship to Wife: Q Natural grandchild Q Stepgrandchild

Name of Grandchild 4 _____ Gender: Q Male Q Female

Relationship to Husband: Q Natural grandchild Q Stepgrandchild
Relationship to Wife: Q Natural grandchild Q Stepgrandchild

Name of Grandchild 5 _____ Gender: Q Male Q Female

Relationship to Husband: Q Natural grandchild Q Stepgrandchild
Relationship to Wife: Q Natural grandchild Q Stepgrandchild

Are all of your grandchildren in good health? Q Yes Q No

Are any of your grandchildren disabled? Q Yes Q No

I. CONTACT PERSON

Name _____

Street Address _____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number _____

Cell Number _____ Fax Number _____

E-mail Address _____

J. YOUR ADVISORS

Name of your of CPA _____

Street Address _____

City_____ State_____ Zip _____

Phone No._____

Name of your Financial Planner? _____

Street Address _____

City_____ State_____ Zip _____

Phone No._____

MISCELLANEOUS

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

If yes, please explain _____

_____

_____

K. REFERRAL

By Whom Were You Referred To This Office?

Name _____

Street Address _____

City_____ State_____ Zip _____

Home Phone Number_____ Work Phone Number _____

Cell Number _____ E-mail Address _____

Referral is: Q Attorney Q Financial Planner

Q Previous Client of Law Firm Q Doctor

Q Social Worker Q Other _____

WHO DO YOU WISHES TO SEVER AS:

TRUSTEE(S)_____

EXECUTOR(S)_____

HEALTH CARE AGENT(s)_____

POWER OF ATTORNEY(s) _____

L. CERTIFICATION

The undersigned hereby represents to: LOUIS LEPORE, ESQ.

and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if 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:

_____

FINANCIAL DISCLOSURE

Last Name of Client_____ **File No._____**

A. <u>ASSETS/LIABILITIES</u>

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING				
SAVINGS				
MONEY MARKET				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE) BLOCK#_____ LOT#_____ EQ. RT _____ REM. FCTR _____				
OTHER REAL ESTATE BLOCK#_____ LOT#_____ EQ. RT _____ REM. FCTR				
OTHER REAL ESTATE				

ADDITIONAL AUTOMOBILES				
ASSETS BROKERAGE/CAP ACCOUNTS	HUSBAND	WIFE	JOINT	LIABILITIES
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
TRADITIONAL IRA/RETIREMENT PLANS				
ROTH IRA				
NURSING HOME DEPOSIT				

PREPAID FUNERAL/CREMATION				
OTHER:				
OTHER:				
TOTALS				

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. _____

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: $__________________________