



4775 Munson Street NW
Canton, Ohio 44718
Telephone: (330) 244-2862
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ASSET & ESTATE PROTECTION PLANNING QUESTIONNAIRE (Single) PERSONAL AND CONFIDENTIAL

Date: _____

BACKGROUND INFORMATION

LEGAL NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

E-MAIL ADDRESS: _____
We do not recommend work emails as these are not considered private, and void the attorney client privilege.

DATE OF BIRTH: _____

U.S. CITIZENSHIP: Yes No

OCCUPATION: _____
Employer

If Widowed, name(s) of deceased spouse(s): _____
First MI Last

First MI Last

If Divorced, name(s) of former spouse(s): _____
First MI Last

First MI Last

MILITARY SERVICE: _____
(Provide Branch & Dates of Service)

FAMILY MEMBERS – CHILDREN

(Please state child's legal name)

Child 1 NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

OCCUPATION (if applicable) _____

DATE OF BIRTH: _____ E-mail: _____

Adopted: Yes No Name of Other Parent _____

Disabled: Yes No If disabled, complete: **Special Needs Section**

Married: Yes No Spouse: _____

Child 1's Children:

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Child 2 NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

OCCUPATION (if applicable) _____

DATE OF BIRTH: _____ E-mail: _____

Adopted: Yes No Name of Other Parent _____

Disabled: Yes No If disabled, complete: **Special Needs Section**

Married: Yes No Spouse: _____

Child 2's Children:

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Child 3 NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

OCCUPATION (if applicable) _____

DATE OF BIRTH: _____ E-mail: _____

Adopted: Yes No

Name of Other Parent _____

Disabled: Yes No

If disabled, complete: **Special Needs Section**

Married: Yes No

Spouse: _____

Child 3's Children:

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Child 4 NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

OCCUPATION (if applicable) _____

DATE OF BIRTH: _____ E-mail: _____

Adopted: Yes No

Name of Other Parent _____

Disabled: Yes No

If disabled, complete: **Special Needs Section**

Married: Yes No

Spouse: _____

Child 4's Children:

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Child 5 NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

OCCUPATION (if applicable) _____

DATE OF BIRTH: _____ E-mail: _____

Adopted: Yes No

Name of Other Parent _____

Disabled: Yes No

If disabled, complete: **Special Needs Section**

Married: Yes No

Spouse: _____

Child 5's Children:

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Child 6 NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

OCCUPATION (if applicable) _____

DATE OF BIRTH: _____ E-mail: _____

Adopted: Yes No Name of Other Parent _____

Disabled: Yes No If disabled, complete: Special Needs Section

Married: Yes No Spouse: _____

Child 6's Children:

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

Name: _____ Date of Birth _____

PARENTS

(Please state parent's legal name)

=====

Father NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

Mother NAME: _____
First MI Last

ADDRESS: _____
Street Number and Name

City State Zip County

PHONE NUMBER(S): _____
Home Cell Work

FINANCIAL & TAX ADVISORS

Name of Stockbroker or financial advisor: _____

Address: _____

Telephone: _____ E-mail: _____

Name of Accountant or tax preparer: _____

Address: _____

Telephone: _____ E-mail: _____

REAL ESTATE - HOME

Address: _____

This property is: A house A mobile home A condominium An apartment

If other, describe: _____

If mobile home: Own the lot Rent the lot

Name(s) on the deed: _____

Is there a mortgage? Yes No Mortgage balance \$ _____

Tax assessor's value \$ _____

What price would you expect to receive if you sold this property? \$ _____

Date of purchase _____ Purchase Price \$ _____

OTHER REAL ESTATE

Address: _____

This property is: A house A mobile home A condominium An apartment

If other, describe: _____

If mobile home: Own the lot Rent the lot

Name(s) on the deed: _____

Is there a mortgage? Yes No Mortgage balance \$ _____

Tax assessor's value \$ _____

What price would you expect to receive if you sold this property? \$ _____

Date of purchase _____ Purchase Price \$ _____

Do you receive rental income? Yes No Monthly rental amount \$ _____

LIFE INSURANCE

Company	Insured/Owner (if different, list both)	Beneficiary	Death Benefit	Loans	Cash Surrender Value
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

MONEY OWED TO YOU

(Loans, mortgages, promissory notes)

Receivable #1:

Names on the note or mortgage _____

Balance due: \$ _____

Can the note or mortgage be sold? Yes No

Amount you could sell it for: \$ _____

Receivable #1:

Names on the note or mortgage _____

Balance due: \$ _____

Can the note or mortgage be sold? Yes No

Amount you could sell it for: \$ _____

RETIREMENT ACCOUNTS

(IRA's, SEP's, 401(k)'s, Keogh, Profit sharing, etc.)
Please provide copy of most recent statement(s).

Company	Type (e.g. IRA)	Beneficiary(ies)	Current Value
			\$
			\$
			\$

ANNUITIES

Please provide copy of most recent statement(s).

Company	Owner	Annuitant	Beneficiary(ies)	Current Value	Current Monthly Payment (if any)
				\$	\$
				\$	\$
				\$	\$

BANK ACCOUNTS

Please provide copy of most recent statement(s).

Checking Accounts:

#1 Name of Bank: _____ Current Balance \$ _____

Name(s) on account: _____

#2 Name of Bank: _____ Current Balance \$ _____

Name(s) on account: _____

Savings Accounts:

#1 Name of Bank: _____ Current Balance \$ _____

Name(s) on account: _____

#2 Name of Bank: _____ Current Balance \$ _____

Name(s) on account: _____

Money Market Accounts:

#1 Name of Bank: _____ Current Balance \$ _____

Name(s) on account: _____

#2 Name of Bank: _____ Current Balance \$ _____

Name(s) on account: _____

CERTIFICATE OF DEPOSIT

Please provide copy of most recent statement(s).

CD #1:

Name of Bank: _____ Amount \$ _____

Name(s) on CD: _____

Maturity date _____

CD #2:

#1 Name of Bank: _____ Current Balance \$ _____

Name(s) on CD: _____

Maturity date _____

MOTOR VEHICLES

Automobiles, Trucks, Boats, Trailers, etc.

Make/Model/Year

Owner's Name(s)

Make/Model/Year

Owner's Name(s)

Additional motor vehicle(s)

Automobile Van Recreational vehicle Truck Boat

Make/Model/Year

Value

Owner's Name(s)

\$ _____

Additional motor vehicle(s)

Automobile Van Recreational vehicle Truck Boat

Make/Model/Year

Value

Owner's Name(s)

\$ _____

BROKERAGE ACCOUNT

Please attach a copy of most recent brokerage statement

Name of brokerage firm: _____

Name(s) on account: _____

Account balance: \$ _____

STOCKS, BONDS & MUTUAL FUNDS NOT IN BROKERAGE ACCOUNT

Company	Owner	Beneficiary(ies)	Current Value
			\$
			\$
			\$

U.S. SAVINGS BONDS

Number of U.S. Savings Bonds: Series E _____ Series EE _____ Series H _____

Has the income tax been paid on the bonds? Yes No

Name(s) on bonds _____

Total cash value of bonds: \$ _____

OTHER ASSETS

Please identify any additional assets you own
that have not been identified above. (i.e. business interests, etc.)

Type of Asset	How Titled	Current Value
		\$
		\$
		\$

ESTATE PLANNING DOCUMENTS

Please check which documents you already have, and **provide us with copies.**

Will

Durable Financial Power of Attorney

Power of Attorney for Health Care

Living Will

Living (revocable) Trust

Irrevocable Trust

Other _____

ESTATE PLANNING

POWER OF ATTORNEY FOR HEALTH CARE

Under Ohio law, you have the right to designate an agent (and alternates) to make health care decisions if you are unable to convey your desires to a physician. This document is called a "Durable Power of Attorney for Health Care." Who do you want to make your health care decisions? Please state names below.

Primary Agent:

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Alternate agent(s):

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Do you want to name your alternates to serve in the order: as listed above OR as co-agent(s)

DURABLE POWER OF ATTORNEY FOR PROPERTY

Under Ohio law, you have the right to designate an agent to make financial decisions on your behalf during your lifetime. This document is called a "Durable Power of Attorney for Property." Who do you want to make your financial decisions?

Primary Agent:

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Alternate agent(s):

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Do you want to name your alternates to serve in the order: as listed above OR as co-agent(s)

LIVING WILL

Ohio law also allows you to sign a "Living Will," in which you can specify whether or not you want your life to be prolonged by artificial hydration and nutrition if either (a) you are in the final stages of a terminal illness and death is close at hand, or (b) you are in a "permanent unconscious state." Before life support can be withdrawn, you have the right to direct that certain individuals be notified.

Do you want a Living Will? Yes No

Individuals to be Notified:

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

Name _____ Relationship _____
First MI Last

Street _____

City, State & Zip _____

Telephone: _____

HIPAA AUTHORIZATION

List the individuals below whom you authorize to receive health information about you.

Name _____ Relationship _____
First MI Last

WILL

Primary Executor _____ Relationship _____
First *MI* *Last*

First Alternate executor _____ Relationship _____
First *MI* *Last*

Second Alternate executor _____ Relationship _____
First *MI* *Last*

TRUST

Primary Trustee _____ Relationship _____
First *MI* *Last*

First Successor Trustee _____ Relationship _____
First *MI* *Last*

Second Successor Trustee _____ Relationship _____
First *MI* *Last*

Do you want to name your alternates to serve in the order: as listed above OR as co-agent(s)

TANGIBLE PERSONAL PROPERTY

Your Will will provide you the opportunity to make a separate writing apart from your Will to list items of tangible personal property to be distributed to certain individuals. If, however, you have any special items that have significant monetary or sentimental value that you want to mention in your Will, please list these below. If you fill out this section, please indicate whether or not the beneficiary is to receive the item upon your death, or after both you and your spouse are deceased.

Item	Beneficiary	Relationship of beneficiary to you	Mark "X" if Beneficiary to receive at your death	Mark "X" if Beneficiary to receive after 2 nd death

PLANNING FOR CHILDREN
Guardianship of Minor or Incapacitated Children

Guardian of the Child's Person (Medical):

Name _____ Relationship _____
First MI Last

Name _____ Relationship _____
First MI Last

Alternate _____ Relationship _____
First MI Last

Alternate _____ Relationship _____
First MI Last

Guardian of the Child's Estate (Financial):

Name _____ Relationship _____
First MI Last

Name _____ Relationship _____
First MI Last

Alternate _____ Relationship _____
First MI Last

Alternate _____ Relationship _____
First MI Last

Distributions To Children

Optional choices for distributing assets to your children:

A. **Outright Distribution.**

NOTE: If a child is under 18 years of age and receives an outright distribution exceeding \$25,000 in value, a guardian of the minor's estate will be appointed by the Probate Court and the law requires that the guardian distribute such assets directly to the minor upon attaining age 18.

B. **In Trust.**

1. Children are to receive their share at a specific age.
Indicate age: _____

2. Children are to receive their share in two (2) installments:
Age for 1st installment (i.e. 22, 25, etc.): _____
Age for 2nd installment (i.e. 3 to 5 years after 1st): _____

3. Children are to receive their share in three (3) installments:
Age for 1st installment (i.e. 22, 25, 30, etc.): _____
Age for 2nd installment (i.e. 3 to 5 years after 1st): _____
Age for 3rd installment (i.e. 3 to 5 years after 2nd): _____

C. **Other wishes:**

Explain: _____

TAKERS OF LAST RESORT

If after you are deceased, if you have no surviving descendants, who should receive your estate?
Select only one of the following:

1. Legal next-of-kin (i.e. parents, if living, otherwise brothers and sisters, etc.)

2. Charities:

Please identify: _____

3. Other:

Please identify: _____

Beneficiary	Relationship of beneficiary to you	Percentage that this beneficiary is to receive

SPECIAL NEEDS

Complete this portion of the questionnaire only if your planning involves an individual with special needs. Your accuracy and completeness in responding to the following questions is critical for proper advice and planning.

Full Name of Beneficiary with Special Needs:

_____ *First* _____ *MI* _____ *Last*

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Cell Phone No.: _____

Date of Birth: _____ Social Security No.: _____

E-mail: _____ Gender: Male Female

Spouse's Name (if any): _____

Diagnosis / Nature of Disability: _____

Beneficiary Receives: SSI SSDI Medicaid Medicare
 Section 8 Housing No Public Benefits
 Other _____

1. Has the Beneficiary filed for or receiving Social Security benefits? Yes No

If Yes, date of filing: _____

Name of Caseworker: _____

Street Address: _____

City, State, Zip: _____

Telephone No.: _____ Fax No.: _____

2. Will the Beneficiary likely be eligible for Medicare with the next 24 months? Yes No

3. Has Beneficiary filed for any other public benefits? Yes No

If Yes, please describe: _____

4. Where is Beneficiary living: At Home At a Group home At an institution

If not at home, please list:

Name of Institution: _____

Street Address: _____

City, State, Zip: _____

Telephone No.: _____

Name of Contact Person at Institution: _____

5. Is the Beneficiary a U.S. Citizen? Yes No

6. If the Beneficiary is not a U.S. Citizen, is he/she a qualified alien? Yes No Don't Know.

7. Is the Beneficiary an adult? Yes No

If Yes, is the Beneficiary: Competent Incompetent

If No, is the Disable Person: A minor expected to be competent at majority (age 18).

A minor expected to be incompetent at majority (age 18).

8. Social Security Office with which Beneficiary has contact:

Name of Caseworker: _____

Street Address: _____

City, State, Zip: _____

Telephone No.: _____ Fax No.: _____

9. Does the Beneficiary have a court-appointed guardianship? Yes No

If Yes, please provide the following:

Name of Court: _____ Case No. _____

Name of Guardian: _____

Street Address: _____

City, State, Zip: _____

Home Phone No.: _____ Cell Phone No.: _____

E-mail: _____

SPECIAL NEEDS TRUST INFORMATION

1. Who will contribute assets to a trust for the Beneficiary?

The Beneficiary. Source of Funds: _____

Settlement / Lawsuit. Anticipated Amount: \$ _____

Inheritance from: _____ Amount: \$ _____

Payment of back benefits from: _____ Amount: \$ _____

Parent(s): _____

Paternal Grandparent(s): _____

Street Address: _____

City, State, Zip: _____

Home Phone No.: _____ Cell Phone No.: _____

E-mail: _____

Maternal Grandparent(s): _____

Street Address: _____

City, State, Zip: _____

Home Phone No.: _____ Cell Phone No.: _____

E-mail: _____

Other(s): _____

Street Address: _____

City, State, Zip: _____

Home Phone No.: _____ Cell Phone No.: _____

E-mail: _____

2. Who should serve as Trustee(s)?

Name _____ Relationship _____
First MI Last

Contact Person (if corporate trustee): _____

Street Address: _____

City, State, Zip: _____

Phone No.: _____ Cell Phone No.: _____

Fax No.: _____ E-mail: _____

Name _____ Relationship _____
First MI Last

Contact Person (if corporate trustee): _____

Street Address: _____

City, State, Zip: _____

Phone No.: _____ Cell Phone No.: _____

Fax No.: _____ E-mail: _____

3. Is the Beneficiary receiving a structured settlement? If yes, provide copy.

Name of Settlement Company: _____

Contact Person: _____

Street Address: _____

City, State, Zip: _____

Phone No.: _____ Cell Phone No.: _____

Fax No.: _____ E-mail: _____

Annuity Contract No.: _____

4. Will the Trust own any real estate? Yes No

If Yes, provide the following: information for the property:

Street Address: _____

City, State, Zip: _____

Single Family Dwelling A mobile home A condominium An apartment

If there are assets remaining after the death of the Beneficiary, to whom should such assets pass:

Individual(s); if so, identify: _____

Charity(ies); if so, identify: _____

ELDER & ASSET PROTECTION PLANNING

Complete this portion if the planning involves protecting assets and long-term care planning.

HEALTH STATUS

Health problems: _____

Current Living Arrangement: At Home In Assisted Living In Nursing Home

If in a Facility: _____

Physician(s): _____

Address: _____

Phone: _____

ACTIVITIES OF DAILY LIVING

Please identify which of the following abilities apply:

Feeds self

Bathes self

Needs help with meds

Speech impaired

Able to sign documents

Able to walk

Other _____

BENEFITS

Has an application for Medicaid, Veteran's benefits, Social Security (SSI or SSDI), or any other public benefit been filed? Yes No

If Yes, type of benefit _____, Date: _____ Approved Denied

AVERAGE MONTHLY INCOME

Source	Gross	Net
Earned Income	\$	\$
Social Security (Add \$54.00 for gross)	\$	\$
Private Pension	\$	\$
Civil Service	\$	\$
Railroad Retirement	\$	\$
IRA Distribution	\$	\$
Annuity	\$	\$
Veterans Benefits	\$	\$
Interest Income	\$	\$
Dividend Income	\$	\$
Alimony	\$	\$
Rental Income	\$	\$
Other Income	\$	\$
Total Income	\$	\$

AVERAGE MONTHLY EXPENSES

(All amounts should be *monthly* amounts. Divide annual expenses by 12)

<i>Monthly Shelter Expenses</i>		<i>Non-Shelter Expenses</i>	
Mortgage	\$	Food	\$
Rent	\$	Life Insurance	\$
Maintenance Expense	\$	Clothing	\$
Real Estate Taxes	\$	Transportation including Auto Insurance	\$
Homeowners/Renters Insurance	\$	Cable TV	\$
Condominium Fees	\$	Federal, State, Local Income Taxes	\$
Lawn care/snow removal	\$		\$

<i>Utilities</i>		<i>Medical Expenses</i>	
Electric	\$	Health Insurance	\$
Gas	\$	Prescriptions	\$
Water	\$	Unreimbursed medical expenses	\$
Sewer	\$	Long Term Care Insurance	\$
Trash Collection	\$		

CURRENT ASSISTED LIVING OR NURSING HOME EXPENSES

Monthly Facility Expense	\$
Monthly Prescription Cost	\$
Monthly Supplies	\$
Monthly Other Cost	\$
Total Monthly Expenses	\$

HEALTH/MEDICAL INSURANCE

Insurance Name	Company Name and Address	Monthly Premium
		\$
		\$

LONG TERM CARE INSURANCE

Insured Name	Company Name	Monthly Benefit	No. of Mos. Of Benefits	Annual Premium

FUNERAL ARRANGEMENTS

Prepaid Funeral Plan: Yes No If Yes: Paid Still paying for

Contract is: Revocable Irrevocable

Contract Amount \$ _____

Own Cemetery Plot Yes No

Funeral Home:

Name _____

Address _____

City, State, Zip _____

Phone _____

GIFTS TO SOMEONE WITHIN THE PAST FIVE YEARS

Please provide information on any gifts made to any person within the last five (5) years.

Gift No. 1 (*i.e. cash, savings bonds, CD, stock, car, real estate, etc.*)

Type of Asset: _____

Beneficiary of gift: _____

Date of gift: _____

Value of gift: \$ _____

Gift No. 2 (*i.e. cash, savings bonds, CD, stock, car, real estate, etc.*)

Type of Asset: _____

Beneficiary of gift: _____

Date of gift: _____

Value of gift: \$ _____

Gift No. 3 (*i.e. cash, savings bonds, CD, stock, car, real estate, etc.*)

Type of Asset: _____

Beneficiary of gift: _____

Date of gift: _____

Value of gift: \$ _____

WHO REFERRED YOU TO OUR OFFICE

Name: _____

Relationship: _____

Seminar Internet Search Other (please specify) _____

DOCUMENTS TO BRING

Please bring the following to your appointment:

Any existing estate planning documents (Will, Powers of Attorney, etc.)

Driver's License

Social Security Card

Most recent brokerage account statement(s)

Most recent federal income tax return

After you have completed the Questionnaire, please sign the following statement:

The undersigned hereby represent to Krugliak, Wilkins, Griffiths & Dougherty Co., L.P.A. and each of its attorneys, that the information contained in this questionnaire is accurate and complete and that the undersigned understand 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.

Sign: _____ Date _____