ASSET PROTECTION QUESTIONNAIRE (MARRIED)

Date_________________ Home Phone No.___________________ Business Phone No. ____________________

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

A. <u>PERSONAL DATA</u>

(Husband)
Full Name__________________________________

(Wife)
Full Name__________________________________

Street Address____

City____ State___________ Zip_____________

(Husband)
Birth Date___________________________________

Social Security No.____________________________

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

(Wife)
Birth Date__________________________________

Social Security No.___________________________

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

B. <u>MEDICAL DATA</u>

1. <u>HEALTH</u>

Name of Ill Spouse ____

Diagnosis ____

Prognosis ____

Course of Treatment ____

Where Ill Spouse Currently Resides ____

Name of Well Spouse ____

Health of Well Spouse ____

Where Well Spouse Currently Resides ____

If either spouse has ever entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis ____

2. PHYSICIAN

(Husband)
Full Name of Primary Physician ____

Street Address ____

City ______________________________ State __________ Zip __________

(Wife)
Full Name of Primary Physician ____

Street Address ____

City ______________________________ State __________ Zip __________

3. **HEALTH INSURANCE**

Do you have a Medicare Supplement Health Policy? Yes ☐ No ☐

If Yes, attach policy of summary of benefits

Do you have Long Term Care Insurance? Yes ☐ No ☐

If Yes, attach policy or summary page of benefits

C. MONTHLY INCOME (Do not include interest and dividend income on this form).

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (include $45.50 Medicare Part B Deduction, if applicable)	$__________	$__________
Retirement Benefits (Gross)	$__________	$__________
VA Disability Benefit	$__________	$__________
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 ☐

D. MONTHLY COST OF NURSING HOME (IF SPOUSE IS CURRENTLY LIVING IN NURSING HOME)

$________________	Monthly Nursing Home Cost
$________________	Monthly Prescription Cost
$________________	Monthly Incontinent Cost
$________________	Monthly Other Cost
$________________	**Total Monthly Costs**

The nursing home is paid through (month/year).

E. **<u>MONTHLY SHELTER EXPENSES</u>** (IF LIVING AT HOME)
(Please divide annual expenses by 12 and quarterly expenses by 3)

$________________	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**

F. **<u>MONTHLY NON-SHELTER LIVING EXPENSES</u>**

$________________	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**

G. <u>ASSETS/LIABILITIES</u>

Please insert the value of each asset/liability in the appropriate space. List all accounts separately. Use a separate page if necessary.

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE)				
OTHER REAL ESTATE				
ADDITIONAL AUTOMOBILES				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

Attach Copies of your last bank statements and investment accounts

Address of Personal Residence:

Street____City________________State__________Zip_________

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

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

Is anyone currently residing in personal residence? Yes ☐ No ☐

When was personal residence purchased? ____

Has the current owner used and occupied the home for the past 2 years? Yes ☐ No ☐

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? $______________________________

Attach copies of deeds for all real property.

Do you expect to inherit or receive any property from any one other than your spouse? Yes ☐ No ☐

If Yes, list the person and the approximate amount you expect to inherit or receive.__________________________
____

Do you have an irrevocable burial plan? Yes ☐ No ☐

If yes, attach copy of plan.

H. <u>GIFTS</u>

Please list all gifts made in the last 3 months. Please list all gifts in excess of $3,000 in any one month, to an individual or group of individuals, within the past 36 months (attach separate sheet if necessary):

Recipient______________________________ Date ______________ Amount __________

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 Yes, please attach copies.

I. Annuities

COMPANY NAME (include address and policy #)	TYPE	DATE PURCHASED	DO YOU RECEIVE PAYMENTS	VALUE	ANNUITANT	OWNER	BENEFICIARY

Attach copies of annuities last statements

J. **<u>CHILDREN</u>** (if applicable)

CHILD'S NAME	ADDRESS (WITH ZIP CODE)	TELEPHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Does the Husband have any children by a previous marriage? Yes ☐ No ☐

Does the Wife have any children by a previous marriage? Yes ☐ No ☐

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

Are any of your children blind? Yes ☐ No ☐

Are any of your children disabled? Yes ☐ No ☐

Have all of your children completed their education? Yes ☐ No ☐

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

Do any of the family members have any problems with:

AIDS? Yes ☐ No ☐
Drug Addiction? Yes ☐ No ☐
Alcoholism? Yes ☐ No ☐
Spendthrift? Yes ☐ No ☐
Marital Problems Yes ☐ No ☐

Please provide details if you answered yes to any of the above questions.______________________________________
____
____

Has any family member live with you in your home? Yes ☐ No ☐

If yes, name of family member, and how long has the family member lived in home with you?
____

K. <u>MISCELLANEOUS</u>

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

If yes, please explain ____

____

12. <u>ATTACHMENTS</u>

Please attach copies of the following documents to this form

1. Deeds to all real property.
2. Annuity Contracts
3. Long Term Care Policies
4. Last Property Tax Assessment
5. Estate Planning Documents including, Last Will and Testament, Revocable Living Trust, Living Will, Financial Durable Power of Attorney, Medical Durable Power of Attorney.
6. Last 2 year income tax returns

7. Life Insurance Policies with latest statement from the Insurance Company regarding cash value and death benefit.
8. Latest account statements received for investments itemized under Part G.

M. REFERRAL

By Whom Were You Referred To This Office?

Name____

Street Address____

City____ State________ Zip__________

N. CERTIFICATION

The undersigned hereby represents to the LAW OFFICES OF BRADLEY J. FRIGON, 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:

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