

**ESTATE PLANNING (& SNT)QUESTIONNAIRE  
(Unmarried)**

Apperson Crump PLC  
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Tel: (901) 756-6300  
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Date \_\_\_\_\_

**This form is extremely important. Your accuracy and completeness in responding will help us best represent you.**

**4-12**

**A. PERSONAL DATA**

Full Name: \_\_\_\_\_

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

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

Telephone: Home: \_\_\_\_\_ Other: \_\_\_\_\_ Cell  Work

May we correspond with you by e-mail? Yes  No  E-Mail Address: \_\_\_\_\_

Age & Birth Date: \_\_\_\_\_ Age & Birth Date: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ U. S. Citizen? Yes  No

Veteran? Yes  No

**Existing Planning Documents:** Do you now have:

Wills? Yes  No

Living trusts? Yes  No

Durable Powers of Attorney? Yes  No

Health Care POA, Living Wills? Yes  No

Irrevocable Life Insurance Trust Yes  No

Special Needs Trust Yes  No

**PLEASE BRING COPIES OF YOUR EXISTING PLANNING DOCUMENTS WITH YOU TO OUR FIRST MEETING.**

**B. BASIC PLANNING CHOICES:**

Do you wish to set up Wills, or Trusts? Wills  Trusts  Not Sure

**Is SPECIAL NEEDS PLANNING for a family member or friend one of the reasons you are coming to us?** Yes  No  Special Needs Beneficiary Questionnaire attached:

**If applicable, please complete the Special Needs Planning Beneficiary Questionnaire** regarding your loved one with disabilities for which you wish to do special needs planning and attach it to this questionnaire.

Special Needs Beneficiary Questionnaire attached:

Name of Special Needs Planning Beneficiary: \_\_\_\_\_

Relationship: \_\_\_\_\_

Comments: \_\_\_\_\_

**C. FIDUCIARIES:**

Note: Provide addresses and contact numbers for any Personal Representatives or Trustees who are not listed in Section D below.

**1. Proposed Personal Representatives:** Who do you each choose to be your Personal Representatives (Executors) in your Wills? Identify a Primary and one or more Alternate Personal Representatives.

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_

**2. Trusts and Trustees.** If you have decided on a Revocable Living Trust and you wish to be the initial Trustee, who do you choose as your Trustees when you are unable to perform your duties as Trustee?

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_

**3. Proposed Agents for Financial Powers of Attorney:**

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_

**4. Proposed Agents for Health Care Powers of Attorney (Health Care Agents):**

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_

**5. SPECIAL NEEDS PLANNING:**

Trustees (and Trust Protectors, if appropriate) proposed for any Special/Supplemental Needs Trusts

**Trustee(s) of the SNT:** \_\_\_\_\_

**Successor Trustees:** \_\_\_\_\_

**Trust Protector(s):** \_\_\_\_\_

Trust Advisory Committee: \_\_\_\_\_

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

Other Comments, questions: \_\_\_\_\_

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

**D. CHILDREN, GRANDCHILDREN**

If you have children, please list them below. If any child is not living in your home, please provide address, contact information.

If you have grandchildren or other persons who you are making provisions for in your estate, please list them and indicate their relationship to you.

1. \_\_\_\_\_ Age: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Telephone: \_\_\_\_\_  
Disabled? \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Ages: \_\_\_\_\_
  
2. \_\_\_\_\_ Age: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Telephone: \_\_\_\_\_  
Disabled? \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Ages: \_\_\_\_\_
  
3. \_\_\_\_\_ Age: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Telephone: \_\_\_\_\_  
Disabled? \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Ages: \_\_\_\_\_
  
4. \_\_\_\_\_ Age: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip Telephone: \_\_\_\_\_  
Disabled? \_\_\_\_\_ Married? \_\_\_\_\_ Divorced? \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Does he/she have children? Number: \_\_\_\_\_ Ages: \_\_\_\_\_

**(Add additional pages if necessary)**

**E. ASSETS/LIABILITIES** Please insert the approximate value of each asset/liability

**NOTE: PLEASE BRING BROKERAGE STATEMENTS, ETC., TO OUR PLANNING MEETINGS.**

ASSETS (explanation if necessary)		Value	Jointly Owned? Name of Joint owner.	Debt/Mortg. Amt
RESIDENCE				
CHECKING & SAVINGS ACCOUNTS				
CERTIFICATES OF DEPOSIT				
BROKERAGE ACCOUNTS				
IRAs				
ANNUITIES				
OTHER REAL ESTATE				
LIFE INSURANCE				
OTHER				
TOTALS				

**Other information. (Anything else we should know about your estate or estate planning?)**

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**F. REFERRAL: How did you hear about us?** \_\_\_\_\_

**Special Needs Beneficiary Information**  
(For use with Estate and Elder Planning Questionnaire)

Information supplied by: \_\_\_\_\_

This information is very important. Your accuracy and completeness in responding will help us to best represent you.

**Note: Check  if we are handling establishment of a guardianship or conservatorship for you:** Please complete and return our form “**Information Needed for Conservatorship Petition**” with this questionnaire.

**Check  if Disabled Person/Beneficiary is able to assist in this Special Needs Planning.**

**A. SPECIAL NEEDS BENEFICIARY/DISABLED PERSON**

Full Name: \_\_\_\_\_

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

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

Phone No. \_\_\_\_\_ E-mail address \_\_\_\_\_

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

U.S. citizen?  Yes  No Veteran?  Yes  No

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

If Adult: Competent to sign documents, make decisions?  Yes  No  Don't know.

Married?  Yes  No Spouse's Name: \_\_\_\_\_

Children?  Yes  No Number of children, ages: \_\_\_\_\_

Has the individual with special needs been determined to be “disabled?” If so, how was the determination made?

Social Security or state disability determination:  Yes  No Date: \_\_\_\_\_

Conservatorship established?  Yes  No Date: \_\_\_\_\_

Other: \_\_\_\_\_

**Describe Disabling Condition, whether he/she is able to live independently:** \_\_\_\_\_

\_\_\_\_\_ Age

at Onset of Disabling Condition: \_\_\_\_\_

**Benefits being received now:**  SSI  SSDI  Medicaid/TennCare  Medicare

Medicaid Waiver/ Group Home  VA Benefits (Describe) \_\_\_\_\_

Other \_\_\_\_\_

No Public Benefits

Private/Group Health Insurance - Through Parent's coverage?  Yes  No

Name of Ins. Carrier: \_\_\_\_\_ Coverage termination date: \_\_\_\_\_

SSI or Social Security Disability application filed, but not yet approved?  Yes  No

If yes, program applied for and date of filing: \_\_\_\_\_

If not now on Medicare, is Disabled Person likely to be eligible for Medicare soon?  Yes  No

Don't know. If yes, date eligibility expected: \_\_\_\_\_

**IS A CONSERVATORSHIP/GUARDIANSHIP NEEDED NOW?**  Yes  No  Don't know

**EXISTING CONSERVATORSHIPS:**

Is the Disabled Person now protected by a guardian or conservator?  Yes  No

Name of Guardian/Conservator(s) \_\_\_\_\_

**Court, jurisdiction in which guardianship/guardianship is established:** \_\_\_\_\_

**Court File Number:** \_\_\_\_\_ **Date established:** \_\_\_\_\_

**PLEASE BRING COURT ORDERS, GUARDIANSHIP LETTERS AND RELATED PLEADINGS TO OUR MEETING.**

**B. FINANCIAL INFORMATION FOR DISABLED PERSON:**

Is the primary purpose of our representation in connection with assets that are owned or being received by the Disabled Person or for estate/special needs planning by parent or other family member?

- Estate/special needs planning by parent or other family member.
- Special Needs Planning regarding Disabled Person's Assets
- Both

**Income received by Disabled Person (Describe type, monthly amounts):**

Social Security Benefits  SSDI  SSI  SS (retirement) \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Regular/monthly gifts from others for living expenses?  Yes  No \$ \_\_\_\_\_

Donor(s): \_\_\_\_\_

**Assets owned by Disabled Person:**

Representative Payee Bank Account \$ \_\_\_\_\_

Other Bank accounts \$ \_\_\_\_\_ Joint with: \_\_\_\_\_

Other Accounts, Investments:

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Please bring copies of any recent bank statements, brokerage statements, etc., or other evidence of any assets in which Disabled Person may have an interest, as well as any existing trusts for his or her benefit.

**Is there an expected inheritance?**  Yes  No Approximate amount expected: \$ \_\_\_\_\_

**Lawsuit settlement pending?**  Yes  No Approximate amount expected: \$ \_\_\_\_\_

**Date inheritance or settlement expected to be received?** \_\_\_\_\_

**If lawsuit settlement is involved, please complete Litigation Intake Questionnaire and return to this office.**