Clingman Law Firm LLC
1522 Richland Street | PO Box 7096
Columbia, South Carolina 29202-7096
Office (803) 787-0557 Fax (803) 782-7607

Sarah Linley Clingman, CELA
Certified Elder Law Attorney
by The National Elder Law Foundation
Certified Circuit Court Mediator
Also admitted in Maryland

CONFIDENTIAL QUESTIONNAIRE
ESTATE PLANNING
Single, Divorced or Widowed

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please answer each question completely. Place N/A in response to any question which does not apply to you.

Person Completing Questionnaire _____

If not Client, Relationship to Client _____

Address _____

_____

Telephone(s) _____

E-mail Address _____

By whom were you referred to this office _____

Specific issues or questions to be addressed_____
_____

CERTIFICATION

We understand that Clingman Law Firm, LLC will rely on the information supplied by us in developing an estate plan. We also understand that inaccurate or incomplete information could negatively impact our plan. Consequently, we agree to provide updated, accurate and complete information as requested within this Questionnaire and Checklist of Documents.

Signature of Client or Client Representative _____

Print Name _____
Date _____

PERSONAL INFORMATION

Client Name _____
Other names known as _____
Address _____
City_____ County _____ State _____ Zip Code_____
Home Phone _____ Work Phone _____
Cell Phone _____ E-mail Address _____
Age _____ Birth Date _____ SSN _____
U.S. Citizen? ☐ Yes ☐ No SC Resident? ☐ Yes ☐ No
Employer _____ Retirement date _____

Veteran? ☐ Yes ☐ No If so, Branch of Service _____
Dates of service ___/___/_____ thru ___/___/_____ Rank at Discharge _____
Were you a prisoner of war during service? ☐ Yes ☐ No
Do you currently receive VA benefits? ☐ Yes ☐ No Type_____

Marital Status: ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed
Please list all marriages
Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date & place of divorce _____
Was this marriage ended by death of spouse? Date & place of death _____

Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date & place of divorce _____
Was this marriage ended by death of spouse? Date & place of death _____

KEY FAMILY INFORMATION

Please list your children, step-children, adopted children or other supportive family members. If you have a deceased child leaving children, please include both the deceased child/their children.

1. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

2. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

3. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

4. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

5. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

6. Relationship _____ Name _____ DOB __/__/____
Address_____
City_____ State _____ Zip Code _____
Home Phone_____ Work Phone _____
Cell Phone _____ E-mail _____

Are all children in good health? ☐ Yes ☐ No
Are any children disabled? ☐ Yes ☐ No
Are any children receiving SSI or other government assistance? ☐ Yes ☐ No
Do all your children get along with one another? ☐ Yes ☐ No
Do any family members have problems with:
Drug addition? ☐ Yes ☐ No Alcohol abuse? ☐ Yes ☐ No
Money management? ☐ Yes ☐ No Their marriage or home life? ☐ Yes ☐ No
Do any children live with you? ☐ Yes ☐ No

HEALTH INFORMATION

Have you been diagnosed with any illness or disability? If so, please provide the following:

1. Physical Conditions and Diagnoses

_____
_____

2. Cognitive Conditions

_____
_____

3. Medications Prescribed

_____

_____

4. Activities of Daily Living

Feeds independently? ☐ Yes ☐ No Dresses independently? ☐ Yes ☐ No
Bathes independently? ☐ Yes ☐ No Transfers independently? ☐ Yes ☐ No
Toilets independently? ☐ Yes ☐ No Requires supervision? ☐ Yes ☐ No

5. Capacity

Able to sign name? ☐ Yes ☐ No Able to read & understand? ☐ Yes ☐ No
Been declared incompetent by court? ☐ Yes ☐ No

6. Primary Physician
Name _____ Office Phone _____
Address_____

_____
Specialty: _____

7. Please list the names of all persons who provide assistance or caregiving to you:

_____

_____

8. Tell us about your parents:

	Mother	Father
Age of Death	_____	_____
Cause of Death	_____	_____

HEALTH INSURANCE

Type	ID#	Carrier	Insured	Premium/Month
Medicare Part A				$
Medicare Part B				$
Medicare Part C				$
Medicare Pat D				$
Medicare Supplement				$
Medicaid				$
Private Health Plan				$
Long Term Care Plan				$
Retiree Health Plan				$
Other				$

ADVISORS

Accountant _____
Address: _____
_____
Telephone: _____ E-mail: _____

Tax Preparer _____
Address: _____
_____
Telephone: _____ E-mail: _____

Financial Advisor _____
Address: _____
_____
Telephone: _____ E-mail: _____

Insurance Agent _____
Address: _____
_____
Telephone: _____ E-mail: _____

ASSET ASSESSMENT

Nonretirement Accounts (Checking & Savings Accounts, CDs, Money Market Accounts, Brokerage Accounts, Stocks, Annuities or US Bonds)

Description	Account #	Value	In Whose Name?

Retirement Plans (IRAs, vested pension plans, annuities, or other assets that would pass on your death to a particular beneficiary that you have designated)

Description	Account #	Value	Beneficiary

Real Estate (Please list your personal residence first; also list,mineral/oil rights)

Description/address	Purchase Date	Purchase Price	Current Value	In Whose Name?

Life Insurance

Insured	Company	Face Value	Cash Value	Policy No	Beneficiary

Other Business Interests

Description	Value	In Whose Name?

Personal Property (Autos, Boats, RVs, Appraised Antiques/Jewelry/Collections, etc)

Description	Value	In Whose Name?

Money Owed to You (promissory notes)

Type	Security	Repayment terms

Burial, Pre-Need Funeral Arrangements

Description	Facility	Paid for?

TOTAL ASSET VALUES $_____

Have you made any transfers or gifts of $1000 or more during the past 5 years? ☐ Yes ☐ No
Recipient _____ Date of Gift _____ Amount $_____
Recipient _____ Date of Gift _____ Amount $_____
Recipient _____ Date of Gift _____ Amount $_____

Do you expect an inheritance? ☐ Yes ☐ No

Are you the beneficiary of any trust? ☐ Yes ☐ No

Liabilities (Please list all mortgages, loans from banks, auto loans, credit cards etc)

Description	Balance Due	Monthly Payment	Secured/Collateral

TOTAL LIABILITIES $_____

RECAP:

TOTAL ASSETS $_____
TOTAL LIABILITIES - $_____
NETWORTH $_____

MONTHLY INCOME & MONTHLY

Monthly Income

Social Security	$
Employment	$
Pension_____	$
IRA _____	$
Annuity_____	$
Rents	$
Business Interest	$
Gas Royalties	$
Other	$
Other	$
Other	$
TOTAL	**$**

Monthly Expenses

Medicare	$
Health Insurance	$
Taxes	$
Nursing Home/Facility	$
Caregivers	$
Prescriptions	$
Monthly Supplies	$
Other Costs	$
Other Costs	$
Other Costs	$
TOTAL	**$**

LEGAL ASSESSMENT

Do you currently have the following estate planning documents in place?

	Date Made	Location of Original
• Durable Power of Attorney Is POA Recorded in County ROD Office? ☐ Yes ☐ No	_____	_____
• Health Care Power of Attorney	_____	_____
• Last Will & Testament	_____	_____
• Living Trust	_____	_____

Location of other important papers _____

I am the legally appointed guardian of _____

I am serving as executor or administrator of an estate _____

I am involved in a lawsuit _____

Other legal concerns _____

_____

_____

_____

In completing new estate planning documents for you, please express your preferences:

☐ **Durable Power of Attorney for Financial Matters**

Who would you like to serve as your agent under a power of attorney?
_____ Relationship to you _____
Full legal name

Who would you like to serve as an alternate agent under your power of attorney?
_____ Relationship to you _____
Full legal name

☐ **Health Care Power of Attorney**

Who would you nominate as your health care agent?
_____ Relationship to you _____
Full legal name
Address: _____ Telephone/Home _____
_____ Telephone/Work _____
_____ Telephone/Cell _____

Who would you nominate as alternate agent #1?
_____ Relationship to you _____
Full legal name
Address: _____ Telephone/Home _____
_____ Telephone/Work _____
_____ Telephone/Cell _____

Who would you nominate as alternate agent #2?
_____ Relationship to you _____
Full legal name
Address: _____ Telephone/Home _____
_____ Telephone/Work _____
_____ Telephone/Cell _____

☐ **Will**

Who would you nominate to serve as the Personal Representative (Executor)?
_____ Relationship to you _____
Full legal name

If your nominee is unable or unwilling to serve, who would you like to serve?
_____ Relationship to you _____
Full legal name

☐ **Trust** (either in the will or separate trust agreement)

Who would you nominate to serve as the Trustee?
_____ Relationship to you _____
Full legal name

If your nominee is unable or unwilling to service, who would you like to serve?
_____ Relationship to you _____
Full legal name

CLIENT GOALS

☐ I would like to update or create new estate planning documents.

☐ I would like to be able to have my family members know what to do should I die.

☐ I would like to be able to have my children/loved ones benefit from my wealth.

☐ I would like to be able to have my family members know what my final wishes are.

☐ I would like to know my children/loved ones are authorized to help when I need help.

☐ I would like to be able to avoid probate.

☐ Other: _____

☐ Other: _____

☐ Other: _____

In general, how would you like your estate distributed at your death?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Checklist of Documents

Please submit the following items prior to your consultation appointment along with your completed questionnaire and consultation fee.

- ☐ COPY of driver's license/ID card, social security card, and health insurance cards
- ☐ COPY of social security and/or retirement annual award letters
- ☐ COPY of military DD Form 214
- ☐ COPY of most current tax notices for all real estate owned
- ☐ COPY of deeds for all real estate owned
- ☐ COPY of titles to all vehicles, boats, RVs etc owned
- ☐ COPY of life insurance policies
- ☐ COPY of current statements for ALL financial assets (checking, savings, CD accounts, investment and brokerage accounts, and retirement accounts)
- ☐ COPY of current health care power of attorney, financial power of attorney, last will and testament/codicils, trust agreements
- ☐ COPY of pre-nuptial agreement, marriage license, separation/divorce decree – for all marriages
- ☐ COPY of adoption papers
- ☐ COPY of business ownership agreements
- ☐ COPY of pre-need/funeral arrangements contract
- ☐ COPY of the past 3 years tax returns and any gift tax returns