



JULIAN GRAY ASSOCIATES

ELDER LAW ♦ ESTATE & DISABILITY PLANNING

AVOID MISTAKES. PROTECT ASSETS.

RETIREMENT PLANNING QUESTIONNAIRE

(PLEASE COMPLETE THIS PACKET IN INK)

This information packet must be returned to us at least three days prior to your meeting (this will ensure we have enough time to understand the specifics of your situation before our meeting). If you need assistance completing the information, call our Client Relations Manager, Courtney Bachik, at (412-458-6000).

DON'T WORRY ABOUT TOTAL ACCURACY – JUST DO THE BEST YOU CAN

WE LOOK FORWARD TO SEEING YOU!!!

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

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[www. GrayElderLaw.com](http://www.GrayElderLaw.com)

**RETIREMENT PLANNING QUESTIONNAIRE
(SINGLE)**

PLEASE BE AWARE no attorney client relationship has been formed by completing or not completing this questionnaire. If we do not receive your completed questionnaire within **thirty (30) days** from the date of receipt, we will close your file and Julian Gray Associates will take no further action on this matter.

Today's Date _____

This form is extremely important. Your accuracy and completeness in responding will help us to assess your situation.

A. PERSONAL DATA

Full Name _____

Street Address _____

City _____ County: _____ State _____ Zip _____

Telephone Number: _____ Email _____

Birth Date _____ Social Security No. _____

U.S. Citizen? Yes No Veteran? Yes No
Date of Discharge: _____

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

_____ (Name of deceased spouse) _____ (Date of death)

Was your former spouse a Veteran? Yes No

If so, Date of Discharge from service: _____

B. MEDICAL DATA

1. PHYSICIAN

Full Name of Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

FOR FIRM USE ONLY:

LE			AF		
CLR	CAV	FMV	OFFICE		
CLR	CAV	FMV	CASE TYPE		

2. STATE PHARMACEUTICAL PLAN

Are you currently on PACE or any other state pharmaceutical plan? Yes No

C. MONTHLY INCOME

Do not include interest and dividend income on this form.

Social Security Benefits (include Medicare Part B Deduction, if applicable) \$ _____

Retirement Benefits (Gross) \$ _____

Veterans Disability Income \$ _____

Annuity Income \$ _____

Rental Income \$ _____

Other 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 SHELTER EXPENSES

(Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage \$ _____

Real Estate Taxes \$ _____

Homeowner's insurance premium \$ _____

Condominium /Homeowner Assoc. fees \$ _____

Total Monthly Housing Expenses \$ _____

E. MONTHLY NON-SHELTER LIVING EXPENSES

Please list any significant monthly non-shelter living expenses not disclosed in E above:

F. GIFTS

Have you made gifts in excess of \$500 in any one month, to an individual or group of individuals, within the past 60 months, or to a trust within the past 60 months? Yes No

If yes, list below:

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 so, for what calendar year(s)? _____

G. 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 \$ _____

H. LONG TERM CARE INSURANCE

Name of Insurance Company _____ Policy # _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Daily Rate: \$ _____ Maximum Payment \$ _____ Duration of Policy _____

I. CHILDREN (if applicable, including adult children)

Check this box if you have No living children (adult or minor)

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Married? _____ Children? _____

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

Are any of your children receiving government benefits such as Social Security disability, SSI, Medicaid or Veteran's Benefits? If so Please specify. Yes _____ No

Do any of your family members have any problems with:

Drug Addiction? Yes No

Alcoholism? Yes No

Spendthrift? Yes No

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

If yes, name of child _____

Does a sibling live in your home with you? Yes No

If yes, name of sibling _____

Is anyone in your immediate or extended family disabled (including any spouses of your children): Yes No

If yes, name and relationship of disabled family member _____

J. PARENTS

Do you have living parents? Yes No

If yes, please check the applicable boxes:

Mother	<input type="checkbox"/>	Father	<input type="checkbox"/>
PA Resident?	<input type="checkbox"/>	PA Resident?	<input type="checkbox"/>
Age?	_____	Age?	_____

K. YOUR ADVISORS: Name Telephone No.

Accountant	_____	_____
Life Insurance Agent	_____	_____
Investment Advisor	_____	_____
Other Attorney	_____	_____
Other Consultant or Advisor	_____	_____

L. CURRENT ESTATE PLAN

Do you have any of the following estate planning documents?

Last Will & Testament Yes No

Financial/General Durable Power of Attorney Yes No if yes, Agent: _____

Healthcare Power of Attorney/Living Will Yes No if yes, Agent: _____

Trusts Yes No

If yes, name of Trust: _____

I do not have any of the types of documents listed above.

M. SAFE DEPOSIT BOX

Do you have a Safe Deposit Box? Yes No

If yes, please provide name of bank where it is located: _____

N. MISCELLANEOUS

Do you own an irrevocable burial account? Yes No

Do you own a cemetery plot or crypt? Yes No

Do you own a firearm? Yes No

Do you have a gun trust? Yes No

Do you have a Medigap (supplemental health insurance) policy? Yes No

If yes, please list the name of the provider and monthly premium _____

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

If yes, please explain.

O. REFERRAL

By whom were you referred to this office?

Name _____

Street Address _____

City _____ State _____ Zip _____

Have you visited our Website? Yes No

Do you have any ideas for improving our Website? If so, please discuss.

P. CERTIFICATION

The undersigned hereby represents to Gray Elder Law, LLC, 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:

Although reasonable value approximations are acceptable, it is important to be certain of the identity of all assets and how they are owned or titled. This Questionnaire provides for identification of assets as owned solely by wife, solely by husband, or as co-owned (either with a spouse or with another).

ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space.

ASSETS	SELF	JOINTLY HELD FUNDS	LIABILITIES
Personal Effects/Household Items	\$	\$	\$
Automobile	\$	\$	\$
Checking Account	\$	\$	\$
Savings Account	\$	\$	\$
Money Market Account	\$	\$	\$
Certificates of Deposit	\$	\$	\$
Residence (Assessed Value) Block # _____ Lot # _____ (Obtain from Tax Bill)	\$	\$	\$
Other Real Estate	\$	\$	\$
Additional Automobiles	\$	\$	\$
Mutual Funds	\$	\$	\$
Stocks	\$	\$	\$
Bonds	\$	\$	\$
Annuities	\$	\$	\$
Cash Value - Life Insurance	\$	\$	\$
IRA	\$	\$	\$
Nursing Home Deposit	\$	\$	\$
Other	\$	\$	\$
Other	\$	\$	\$
TOTALS	\$	\$	\$

What did you pay for your current home including any improvements? \$ _____

Do you own any real property other than personal residence? _____

Address: _____