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WILL INFORMATION QUESTIONNAIRE

THIS IS NOT A WILL! ALL INFORMATION PROVIDED ON THIS FORM IS PRIVILEDGE & CONFIDENTIAL.

Our office will use the information on this form to prepare the documents you have requested, and will call you to discuss any questions we may have, as well as any questions you may have.

Atty. Melvyn R. Burrow

ABOUT YOU

Date: ____________________

Full Name: ____
(No Initials Please) First Middle Last

Are you known by any other name? ☐ Yes ☐ No If yes, other name is: ____________________

Home Address: ____
Street City State Zip County

Phone #: ____________________ E-mail: ____________________

Date of Birth: ____________________

Are you a U.S. Citizen? ☐ Yes ☐ No Are you currently married? ☐ Yes ☐ No

If married, do you want a divorce? ☐ Yes ☐ No

Have you ever been married before? ☐ Yes ☐ No If yes: ☐ Divorced ☐ Widowed Date: __________

Are either of your parents living? ☐ Yes (Father) ☐ Yes (Mother) ☐ No

Do you have any living siblings? ☐ Yes ☐ No

ABOUT YOUR SPOUSE

Full Name: ____
(No Initials Please) First Middle Last

Is your spouse known by any other name? ☐ Yes ☐ No If yes, other name is: ____________________

Date of Birth: ____________________

Is your spouse a U.S. Citizen? ☐ Yes ☐ No

Spouse's Residence: ☐ Georgia ☐ Other: ____________________

Other state(s) where you and your spouse have lived since your wedding: ____________________

Was your spouse married previously? ☐ Yes ☐ No If yes: ☐ Divorced ☐ Widowed Date: __________

Are either of your spouse's parents living? ☐ Yes (Father) ☐ Yes (Mother) ☐ No

Does your spouse have any living siblings? ☐ Yes ☐ No

ABOUT YOUR CHILDREN & DEPENDENTS

Do you have any living children? ☐ Yes ☐ No Any deceased children? ☐ Yes ☐ No

Do you have any living grandchildren? ☐ Yes ☐ No

Will you have or adopt children or additional children in the near future?

☐ Currently Expecting ☐ Adoption in Progress ☐ Maybe Later ☐ No

Please list each child (or other person for whom you provide care and support) and check each item that applies. *(Please check all that apply. Attach additional sheet if necessary)*

Child's Full Name: ______________________ Date of Birth: __________ Age: ______

☐ Yours *and* Spouse's ☐ Yours ☐ Spouse's ☐ Lives at home ☐ Lives somewhere else

---

Child's Full Name: ______________________ Date of Birth: __________ Age: ______

☐ Yours *and* Spouse's ☐ Yours ☐ Spouse's ☐ Lives at home ☐ Lives somewhere else

---

Child's Full Name: ______________________ Date of Birth: __________ Age: ______

☐ Yours *and* Spouse's ☐ Yours ☐ Spouse's ☐ Lives at home ☐ Lives somewhere else

---

Child's Full Name: ______________________ Date of Birth: __________ Age: ______

☐ Yours *and* Spouse's ☐ Yours ☐ Spouse's ☐ Lives at home ☐ Lives somewhere else

---

Child's Full Name: ______________________ Date of Birth: __________ Age: ______

☐ Yours *and* Spouse's ☐ Yours ☐ Spouse's ☐ Lives at home ☐ Lives somewhere else

---

Child's Full Name: ______________________ Date of Birth: __________ Age: ______

☐ Yours *and* Spouse's ☐ Yours ☐ Spouse's ☐ Lives at home ☐ Lives somewhere else

BURIAL AND CREMATION

It is traditional to state in your Will your desires about burial and cremation. Please note; however, that since your Will may not be read until after your funeral, you should make sure that your loved one know your desires while you are still living to make sure your wishes are followed. Also, if you have an Advance Directive for Health Care, your agent under the Advance Directive for Health Care has authority to decide what happens to your remains.

Do you have preference with regard to burial or cremation? ☐ Yes ☐ No

☐ **Burial** (Where?): ______________________________

☐ **Cremation**

☐ Ashes disposed of as follows: ______________________________

____

☐ Ashes scattered or otherwise disposed of as directed by: ____________________

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YOUR HOME OR LAND

Do you own your home or land? ☐ Yes ☐ No Value: $ ____________ Mortgage: $ ____________

Does anyone else own your home or land with you? ☐ Yes ☐ No

If yes, who owns the home or land with you? ____________

Who should receive your home or land at your death? ____________

What if that person does not survive you, who should get it next? ____________

TANGIBLE PERSONAL PROPERTY

Tangible personal property includes personal effects, furniture, clothes, cars, collections, jewelry, electronics, knick-knacks, and so forth, as distinguished from money, bank accounts, stocks, bonds, etc…

Who should receive your tangible personal property? ____________

What if that person does not survive you, who should get it next? ____________

Do you want to give any specific gifts of any particular personal property? ☐ Yes ☐ No
(If "yes", please attach the Inventory List showing the item(s) and the person who should get the item.)

REMAINDER OF PROPERTY

This is the section of your Will that disposes of your money, investments, and any other property that is not specifically dealt with in earlier sections of your Will.

Who should receive the rest of your property? ____________

What if that person does not survive you, who should get it next? ____________

If none of your named beneficiaries survive you, who should receive your property?

☐ House of worship or other charity *(Please specify)* ____________

☐ Other *(Please specify)* ____________

☐ The persons who would inherit from me under Georgia law if I died without a Will:

1. To your Spouse, if you have no children,
2. To your Spouse and children in equal shares (but your Spouse gets 1/3),
3. To your children, if you have no spouse,
4. To your parents who survive you,
5. To your brothers and sisters,
6. To your grandparents who survive you,
7. To your aunts and uncles who survive you, followed by your closest next of kin
8. To the County Education Fund if no other family survives you.

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EXECUTOR

Your *Executor* is the person who will carry out the instructions in your Will. Any individual who is over the age of 18 may serve as an Executor of an estate. Your spouse may serve as Executor, but that is not required. An Executor does not have to live in the same state as you, but it will be much easier for a local Executor to administer your estate than for an Executor who lives someplace else. Many banks will serve as Executor, but they charge a fee for doing so. Your Executor need not be a lawyer or a financial expert, but your Executor has very broad powers with regard to your property, and therefore should be someone who is *intelligent* enough to ask for help from professionals when needed (accountants, lawyers, investment advisors, etc.), is *honest* and completely trustworthy, and is *responsible* enough to "get things done" and see them through to completion.

Who should be your Executor? *(Please list in order of preference)*

FIRST

Name: ______________________ Relationship: ______________

Address: ______________________

Phone #: ______________________

(Home) (Mobile) (Work)

SECOND

Name: ______________________ Relationship: ______________

Address: ______________________

Phone #: ______________________

(Home) (Mobile) (Work)

THIRD

Name: ______________________ Relationship: ______________

Address: ______________________

Phone #: ______________________

(Home) (Mobile) (Work)

REPORTS AND BOND

The law provides that your Executor must file *periodic reports* to the probate court showing the assets in your estate, income to the estate, distributions, etc., so that the court can supervise the Executor's activities, *unless* you direct that reports are not necessary. Likewise, the law also requires that an Executor post a *bond* (a type of insurance policy) with the probate court to protect the estate from theft or mismanagement by the Executor, *unless* you direct that a bond is not necessary. Reports and bonds provide extra protection against a dishonest or careless Executor, but they also substantially increase the work of the Executor and the cost of administering the estate. In most cases, where the Executor is a trusted relative or friend, the Executor is not required to file reports and posting bonds.

Do you want to require Reports and Bonds?

☐ **No,** reports and bonds are not necessary. I am comfortable with the Executor acting without any supervision from the court, and am willing to accept the risk that the estate may suffer a loss that could have been prevented by court supervision and/or a bond.

☐ **Yes,** reports and bonds should be required; I want my Executor to be closely supervised.

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Estate Planning Inventory List

Client Name: ______________________________ Phone #: ______________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
a. Home							
b. Other Real Estate							
1)							
2)							
3)							
4)							
c. Checking Accounts							
1)							
2)							
3)							
4)							
d. Savings Accounts & Certificates							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ____________________________ Phone #: ____________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
e. Credit Union Accounts							
1)							
2)							
3)							
4)							
f. Automobiles							
1)							
2)							
3)							
4)							
g. Household Furnishings							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ___________________________ Phone #: ___________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
h. U.S. Savings Bond							
1)							
2)							
3)							
4)							
i. Other Bonds							
1)							
2)							
3)							
4)							
j. Stocks							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ____________________________ Phone #: ____________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
k. Accounts Receivables							
1)							
2)							
3)							
4)							
l. Rents Receivable							
1)							
2)							
3)							
4)							
m. Notes Receivable							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ___________________________ Phone #: ___________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
n. Annuities							
1)							
2)							
3)							
4)							
o. Interest in any Business							
1)							
2)							
3)							
4)							
p. Sub Chapter "S' Business							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ____________________________ Phone #: ____________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
q. Tools & Firearms							
1)							
2)							
3)							
4)							
r. Antiques							
1)							
2)							
3)							
4)							
s. Jewelry							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ___________________________ Phone #: ___________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
t. Oils, Gas & Other Minerals							
1)							
2)							
3)							
4)							
u. Other Household Contents (silverware, dishes, etc...)							
1)							
2)							
3)							
4)							
v. Collections/Coins							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ____________________________ Phone #: ____________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
w. Interest under any Executory Contracts							
1)							
2)							
3)							
4)							
x. Escrows or Deposits							
1)							
2)							
3)							
4)							
y. Deferred Compensation							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ____________________________ Phone #: ____________________________

Assets:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
z. Plans							
aa. Miscellaneous							
1)							
2)							
3)							
4)							
bb. Life Insurance Policies							
1)							
2)							
3)							
4)							
cc. Qualified Retirement							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ____________________________ Phone #: ____________________________

Debts:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
a. Mortgage on Home, Car, etc.							
1)							
2)							
3)							
4)							
b. Signature Loan at bank							
1)							
2)							
3)							
4)							
c. Current debt (Utilities, etc.)							
1)							
2)							
3)							
4)							

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Estate Planning Inventory List

Client Name: ____________________________ Phone #: ____________________________

Debts:	Value	Joint or Marital Property	Husband's Separate Property	Wife's Separate Property	Beneficiary 1	Beneficiary 2	Residual Estate
d. Medical or other Expenses							
1)							
2)							
3)							
4)							
e. Other Debts							
1)							
2)							
3)							
4)							
f. Contingent Liabilities							
1)							
2)							
3)							
4)							

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GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE QUESTIONNAIRE

Atty. Melvyn R. Burrow

THIS IS NOT A HEALTHCARE DIRECTIVE!
ALL INFORMATION PROVIDED ON THIS FORM IS PRIVILEDGE & CONFIDENTIAL.

Our office will use the information on this form to prepare the documents you have requested, and will call you to discuss any questions we may have, as well as any questions you may have.

Full Name: ________________________________ Date of Birth: ______________
(Print Name) First Middle Last

Phone #: ______________________ E-mail: ______________________________

This State of Georgia Advance Directive For Healthcare has four parts:

PART ONE – Health Care Agent. This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO – Treatment Preferences. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART Two becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE – Guardianship. This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR – Effectiveness and Signatures. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out the PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people to might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE – Health Care Agent

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.

1. Health Care Agent

I select the following person as my health care agent to make health care decisions for me:

Name: ______________________________

Address: ______________________________

Phone #: ______________________________

(Home) (Mobile) (Work)

2. Back-Up Health Care Agent(s)

(This section is optional. PART ONE will be effective even if this section is left blank.)

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: ______________________________

Address: ______________________________

Phone #: ______________________________

(Home) (Mobile) (Work)

Name: ______________________________

Address: ______________________________

Phone #: ______________________________

(Home) (Mobile) (Work)

3. General Powers of Health Care Agent

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to oblige me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

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In addition to the other powers granted in this Georgia Advance Directive for Health Care, I grant to my health care agent the power and authority to serve as my personal representative for all purposes of the federal or state law related to privacy medical records, including the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPPA"), during any time my health care agent is exercising authority under this document. Pursuant to HIPAA, I specifically authorize my health care agent as my HIPPA personal representative to request, receive and review any information, medical and hospital records; to execute on my behalf any documents necessary or desirable to implement the health care decisions that my health care agent is authorized to make under this document. By signing this document, I specifically employer and authorize my physician, hospital or health care provider to release any and all medical records to my health agent or my health care agent's designee. Further, I waive any liability to any physician, hospital or any health care provider who releases any and all of my medical records to my health care agent.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia Law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

4. Guidance for Health Care Agent

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. Powers of Health Care Agent after Death

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

__x______ *(Initials)* **My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).**

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below. (*Initial each statement that you want to apply.)*

________ *(Initials)* **My health care agent <u>will not</u> have the power to make a disposition of my body for use in a medical study program.**

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________ **My health care agent <u>will not</u> have the power to donate any of my organs.**
(Initials)

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

________ **I want the following person to make decisions about the final disposition of my body:**

Name: ____

Address: ____

Phone #: ____
(Home) (Mobile) (Work)

I wish for my body to be:

________ **Buried**
(Initials)

________ **Cremated**
(Initials)

PART TWO – Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

6. Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

________ **A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.**
(Initials)

________ **A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.**
(Initials)

7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), State your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

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If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) ________ *(Initials)* **Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.**

OR

(B) ________ *(Initials)* **Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.**

OR

(C) ________ *(Initials)* **I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:**

Initial each statement that you want to apply to option (C).

________ *(Initials)* **If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.**

________ *(Initials)* **If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.**

________ *(Initials)* **If I need assistance to breathe, I want to have a ventilator used.**

________ *(Initials)* **If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.**

8. Additional Statements

This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happened to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.

9. In Case of Pregnancy

PART TWO will be effective if this section is left blank.

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

________ *(Initials)*

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PART THREE – Guardianship

PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointment, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will service your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

10. Guardianship

State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.

(A) ________ *(Initials)* **I nominate the person serving as my health care agent under PART ONE to serve as my guardian.**

OR

(B) ________ *(Initials)* **I nominate the following person to serve as my guardian:**

Name: ____________________

Address: ____________________

Phone #: ____________________
(Home) (Mobile) (Work)

PART FOUR – Effectiveness and Signatures

This Georgia Advance Directive For Healthcare will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

________ *(Initials)* **This Georgia Advance Directive For Healthcare will become effective on or upon _____ and will terminate on or upon _________.**

Atty. Melvyn R. Burrow