



FERNANDEZ
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Date: _____

**PROBATE/TRUST ADMINISTRATION QUESTIONNAIRE
CONFIDENTIAL INFORMATION**

Instructions | Please print clearly

Please complete this form to the best of your ability so that we may provide the most informative consultation. Print additional pages if needed.

Name: _____

Relationship to the deceased: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____



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**PROBATE/TRUST
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CONFIDENTIAL INFORMATION**

**INFORMATION
ABOUT THE
DECEASED**

Name: _____

Address: _____

City, State, Zip: _____

Date of Death: _____

Marital status at the time of death: _____

Does the deceased have a Will? Yes No Does the deceased have a Trust? Yes No

**FAMILY OF
THE DECEASED**

Spouse

If deceased, only
name and date of
death are needed

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

Employer: _____ Retirement Date: _____

Employer Address: _____

City, State, Zip: _____

If deceased, date of death: _____



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**FAMILY OF
THE DECEASED**

Parents

If deceased, only
name and date of
death are needed

Mother's Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Father's Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Children

If deceased, only
name and date of
death are needed

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____



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**FAMILY OF
THE DECEASED**

Children

If deceased, only
name and date of
death are needed

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

If deceased, date of death: _____



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Siblings
Required only if
the deceased has
no surviving
spouse, no
surviving parents,
and did not
have children

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ SS #: _____



DEBTS

Does the deceased have debts (i.e. nursing home, hospital, medical, credit cards, or other outstanding bills)?

Yes No If so, please provide copies.

Has the deceased or the spouse of the deceased, during the last 90 days, had substantial medical expenses such as nursing home or hospital bills which have not been paid and are not expected to be paid by Medicare, Medigap insurance, long-term care insurance, or other insurance. If so, please provide details and dates of such medical expenses:

Has a family member or other party been paying bills for the deceased? Yes No

If so, please provide details: _____

Has the deceased filed all federal and state tax returns on a timely basis? Yes No

REAL ESTATE

Home Address: _____

Name(s) on Deed: _____

Mortgage Balance: \$ _____ Market Value: \$ _____

Beneficiary Deed: _____

Other Real Estate Property Address: _____

Name(s) on Deed: _____

Mortgage Balance: \$ _____ Market Value: \$ _____

Beneficiary Deed: _____



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VEHICLES

Make/Year: _____

Name(s) on Title: _____

Loan Balance: \$ _____ Market Value: \$ _____

Transfer on Death: _____

Make/Year: _____

Name(s) on title: _____

Loan Balance: \$ _____ Market Value: \$ _____

Transfer on Death: _____

**ACCOUNTS &
INVESTMENTS**

**Savings
Account(s)**

Bank: _____ Account #: _____

Name(s) on Account: _____

Average Balance: \$ _____

Payable on Death Beneficiaries: _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Balance: \$ _____

Payable on Death Beneficiaries: _____

**Checking
Account(s)**

Bank: _____ Account #: _____

Name(s) on Account: _____

Balance: \$ _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Balance: \$ _____



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**PROBATE/TRUST
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**ACCOUNTS &
INVESTMENTS**
**Bank Certificate
of Deposit**

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: \$ _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: \$ _____

Mutual Funds

Name of Fund: _____ Account #: _____

Name(s) on Account: _____

Value: \$ _____

Name of Fund: _____ Account #: _____

Name(s) on Account: _____

Value: \$ _____

Stocks & Bonds

Name of Brokerage Co.: _____

Purchase Date: _____ # of Shares: _____ Value: \$ _____

Name of Brokerage Co.: _____

Purchase Date: _____ # of Shares: _____ Value: \$ _____

Name of Brokerage Co.: _____

Purchase Date: _____ # of Shares: _____ Value: \$ _____



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**ACCOUNTS &
INVESTMENTS**

**IRAs, Keoughs,
401(k) Plans,
Annuities, etc.**

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: \$ _____

Bank: _____ Account #: _____

Name(s) on Account: _____

Value: \$ _____

INSURANCE

Life

Company: _____ Policy #: _____ Whole Term

Policy Owner: _____ Insured: _____

Beneficiary: _____ Contingent Beneficiary: _____

Face Value: \$ _____ Cash Surrender Value: \$ _____

Company: _____ Policy #: _____ Whole Term

Policy Owner: _____ Insured: _____

Beneficiary: _____ Contingent Beneficiary: _____

Face Value: \$ _____ Cash Surrender Value: \$ _____