The **POCKET LAWYER®** Document Preparation Service

COMPLETE Revocable Living Trust Agreement Client Questionnaire

INSTRUCTIONS: Answer All questions with an answer or a N/A. Today's date (mm/dd/yyyy) _____
If more space is needed, use the space below or attach blank pages.

1	Select one of the following Trust situations that best fits your needs (*select only one*)				
2	☐ Husband and wife as grantors and co-trustees, for their lifetime use, then to others (regular trust)				
3	☐ Husband and wife as grantors and co-trustees, for their lifetime use, then two trusts created until surviving spouse's death (AB trust)				
4	☐ Grantor as trustee, for lifetime use by grantor, then to others				
5	☐ Grantor and third party as co-trustees, for lifetime use of grantor, then to others				
6	☐ Grantor to third party as trustee, for lifetime use by grantor, then to others				
7	Trust creator's first name	Middle	Last		
8	Street address	City	State	Zip	
9	Contact Phone	Fax	E-mail		
10	Trust creator spouse's first name	Middle	Last		
11	Street address	City	State	Zip	
12	1st Co-trustee's first name	Middle	Last		
13	Street address	City	State	Zip	
14	2nd Co-trustee's first name	Middle	Last		
15	Street address	City	State	Zip	
16	1st Successor trustee's first name	Middle	Last		
17	Street address	City	State	Zip	
18	2nd Successor trustee's first name	Middle	Last		
19	Street address	City	State	Zip	
If additional space is needed, number and insert below.					

Revocable Living Trust Agreement (continued)					
20	*List the name(s), address(es), relationship and description and amount or percentage of property to be given to each beneficiary. Attach additional sheet(s) if needed.*				
21	1st Beneficiary's first name		Middle	Last	
22	Street address				
23	City			State	Zip
24	Relationship	Property description and amount or percentage			
25	2nd Beneficiary's first name		Middle	Last	
26	Street address				
27	City			State	Zip
28	Relationship	Property description and amount or percentage			
29	3rd Beneficiary's first name		Middle	Last	
30	Street address				
31	City			State	Zip
32	Relationship	Property description and amount or percentage			
33	4th Beneficiary's first name		Middle	Last	
34	Street address				
35	City			State	Zip
36	Relationship	Property description and amount or percentage			
37	5th Beneficiary's first name		Middle	Last	
38	Street address				
39	City			State	Zip
40	Relationship	Property description and amount or percentage			
41	6th Beneficiary's first name		Middle	Last	
42	Street address				
43	City			State	Zip
44	Relationship	Property description and amount or percentage			

Revocable Living Trust Agreement (continued)			
45a	The following is a list of the items or property that are to be incorporated into this Living Trust:		
45b	DESCRIPTION	LOCATION	
45c	(Complete Appendix "A", *Asset Inventory table*)		
46	Do you want beneficiaries under a certain age to have their property held in trust until they reach a specified age? ☐No ☐Yes If yes, what age must they attain:		
47	Do you want the trustees to serve without bond? ☐No ☐Yes		
48	**POUR-OVER WILL INFORMATION** *A Pour-Over will is used to put property that was not transferred into the Trust while a Trustor was alive, into the Trust after the Trustor's death, and to appoint a Guardian for your minor children.*		
49	Are there current Wills for:	a) Trustor ☐ Yes ☐ No	b) Spouse ☐ Yes ☐ No
50	If so, where are they located?	a) (H)	b) (W)
51	**Sole Trustor's (or Husband's) Will Information:**		
52	Do you wish to have your property that may not have been transferred into your Living Trust while you were alive, transferred into your Living Trust after your death? ☐ Yes ☐ No		
53	Who do you want to be your Personal Representative (executor) or joint personal representatives?		
54	1) Name	Address	
55	2) Name	Address	
56	Alternate person(s) if one of the above is unable to serve as your personal representative?		
57	1) Name	Address	
58	2) Name	Address	
59	Who do you want to be the Guardian or joint guardians of your minor child(ren)?		
60	1) Name	Address	
61	2) Name	Address	
62	Alternate person(s) if one of the above is unable to serve as the guardian of your minor children?		
63	1) Name	Address	
64	2) Name	Address	
65	**Spouse's Will Information:**		
66	Do you wish to have your property that may not have been transferred into your Living Trust while you were alive, transferred into your Living Trust after your death? ☐ Yes ☐ No		
67	Who do you want to be your Personal Representative (executor) or joint personal representatives?		
68	1) Name	Address	
69	2) Name	Address	

Revocable Living Trust Agreement (continued)		
70	Alternate person(s) if one of the above is unable to serve as your personal representative?	
71	1) Name	Address
72	2) Name	Address
73	Who do you want to be the Guardian or joint guardians of your minor child(ren)?	
74	1) Name	Address
75	2) Name	Address
76	Alternate person(s) if one of the above is unable to serve as the guardian of your minor children?	
77	1) Name	Address
78	2) Name	Address

79	**GENERAL POWER OF ATTORNEY INFORMATION**			
80	**Sole Trustor's (or Husband's) power of attorney information**			
81	**Designation of Agent (**Attorney in Fact**)** *(Information about the person who will act for you as your agent in financial and other matters)*			
82	First name	Middle	Last	
83	Street address			
84	City		State	Zip
85	**First Alternate Agent** *(Information about the person who will serve as your agent if your first choice is unable to serve)*			
86	First name	Middle	Last	
87	Street address			
88	City		State	Zip
89	**Second Alternate Agent** *(Information about the person who will serve as your agent if your first and second choice are unable to serve)*			
90	First name	Middle	Last	
91	Street address			
92	City		State	Zip
93	**Designation of Powers** *(Check each power you would like to give your agent; check the first box if you want ALL of them)*			
94	☐ ALL OF THE POWERS LISTED BELOW			
95	☐ Real estate matters			
96	☐ Tangible personal property transactions			
97	☐ Stock and bond transactions			

Revocable Living Trust Agreement (continued)			
98	☐ Commodity and option transactions		
99	☐ Banking and other financial institution transactions		
100	☐ Business operating transactions		
101	☐ Insurance and annuity transactions		
102	☐ Estate, trust, and other beneficiary transactions		
103	☐ Claims and litigation		
104	☐ Personal and family maintenance		
105	☐ Benefits from social security, Medicare, Medicaid, or other governmental programs, or civil or military service		
106	☐ Retirement plan transactions		
107	☐ Tax matters		
108	**Additional Powers** *(List any special instructions limiting or extending the powers granted to your agent)*		
109	Normally, your agent is required by law to keep his or her money separate from yours. If your agent is your spouse or other close family member, and your finances are already commingled (mixed), do you want your agent to be able to continue to commingle (mix) your funds with his or her own? ☐ Yes ☐ No		
110	Normally, your agent is not permitted to financially benefit from any actions taken on your behalf. If your agent is your spouse or other close family member, and your financial interests are already intertwined with yours, do you want your agent to be able to financially benefit from any transactions taken on your behalf? ☐ Yes ☐ No		
111	Do you want your agent to be compensated for acting as your attorney-in-fact? ☐ Yes ☐ No		
112	Would you like to protect your agent and others from liability when they are acting on this Power of Attorney, as long as they are acting in good faith? ☐ Yes ☐ No		
113	Do you want this Power of Attorney to remain in force and be effective even though you become incapacitated? ☐ Yes ☐ No		
114	If you appointed more than one agent, do you want them to be able to act alone (separately) without the other agent joining, or do you want all of your agents to act or sign together (jointly)? ☐ Separately ☐ Jointly		
115	I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party has actual knowledge of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney. ☐ Yes ☐ No		
116	☐ Other *(specify)*		
117	**Duration**		
118	When do you want this Power of Attorney to become effective: ☐ Immediately upon signing by me. ☐ Only if I become mentally incapacitated.		
119	How long do you want this Power of Attorney to be in force: ☐ Until revoked by me in writing. ☐ For the following period of time only (*specify*):		
120	**Spouse's power of attorney information**		
121	**Designation of Agent (**Attorney in Fact**)** *(Information about the person who will act for you as your agent in financial and other matters)*		
122	First name	Middle	Last

Revocable Living Trust Agreement (continued)				
123	Street address			
124	City		State	Zip
125	**First Alternate Agent** *(Information about the person who will serve as your agent if your first choice is unable to serve)*			
126	First name	Middle	Last	
127	Street address			
128	City		State	Zip
129	**Second Alternate Agent** *(Information about the person who will serve as your agent if your first and second choice are unable to serve)*			
130	First name	Middle	Last	
131	Street address			
132	City		State	Zip
133	**Designation of Powers** *(Check each power you would like to give your agent; check the first box if you want ALL of them)*			
134	☐ ALL OF THE POWERS LISTED BELOW			
135	☐ Real estate matters			
136	☐ Stock and bond transactions			
137	☐ Commodity and option transactions			
138	☐ Banking and other financial institution transactions			
139	☐ Business operating transactions			
140	☐ Insurance and annuity transactions			
141	☐ Estate, trust, and other beneficiary transactions			
142	☐ Claims and litigation			
143	☐ Personal and family maintenance			
144	☐ Benefits from social security, Medicare, Medicaid, or other governmental programs, or civil or military service			
145	☐ Retirement plan transactions			
146	☐ Tax matters			
147	**Additional Powers** *(List any special instructions limiting or extending the powers granted to your agent)*			
148	Normally, your agent is required by law to keep his or her money separate from yours. If your agent is your spouse or other close family member, and your finances are already commingled (mixed), do you want your agent to be able to continue to commingle (mix) your funds with his or her own? ❑ Yes ❑ No			
149	**HEALTH CARE DIRECTIVE INFORMATION (*LIVING WILL*)**			
150	**Sole Trustor's (or Husband's) health care directive information**			
151	Name of sole trustor (or Husband)			

Revocable Living Trust Agreement (continued)			
152	Social Security		Birth date (mm/dd/yyyy)
153	*List information about the person you wish to designation as your Agent to Make Health Care Decisions (Attorney in Fact), when you are unable to make your own decisions:*		
154	Name of Agent		
155	Address		
156	City	State	Zip
157	Name of Alternate Agent		
158	Address		
159	City	State	Zip
160	*Choose the powers your AGENT has in dealing with your health care decisions:*		
161	☐ Authorized to make ALL health care decisions, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.		
162	☐ Authorized to make ALL health care decisions except the following:		
163	*Choose the Powers your AGENT has in dealing with your medical records:*		
164	☐ To receive information regarding my physical and mental health, including access to my medical and hospital records.		
165	☐ To execute releases to obtain medical and hospital records and information.		
166	☐ To consent to the disclosure of this information.		
167	*Choose the powers your AGENT has in dealing with waivers and releases:*		
168	☐ To sign documents entitled "Refusal to permit treatment" and "Leaving hospital against medical advise", or similar.		
168	☐ To sign any necessary waiver or release from liability required by a hospital or physician.		
170	*Choose the powers your AGENT has in dealing with the following:*		
171	☐ Authorize an autopsy.		
172	☐ Make a disposition of a part or parts of my body as an Anatomical Gift for use in another.		
173	☐ Make a disposition of a part or parts of my body as an Anatomical Gift for educational or scientific purposes.		
174	☐ Direct the disposition of my remains (burial, cremation, etc.).		
175	*Specify the length of this Health Care Power of Attorney:*		
176	☐ Unlimited Duration, until revoked by me at a later date.		
177	☐ This Power of Attorney expires on: ☐ My death or ☐ Date: _____		
178	*Specify when your AGENT's authority becomes effective:*		

Revocable Living Trust Agreement (continued)	
179	☐ My AGENT's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.
180	☐ My AGENT's authority to make health care decisions for me takes effect immediately.
181	**Desires Regarding Life Sustaining Treatment**
182	*Choose ONE of the following paragraphs; 183, 184, 185 or 186. If 183 is selected, mark each sub-paragraph that applies.*
183	Choose all that apply: ☐ I do not want my life to be prolonged and I do not want life-sustaining treatments if I have an incurable and irreversible condition that will result in my death within a relatively short time. ☐ I do not want my life to be prolonged and I do not want life-sustaining treatments if I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness. ☐ I do not want my life to be prolonged and I do not want life-sustaining treatments if the risks and burdens of treatment would outweigh the expected benefits. ☐ I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.
184	☐ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards, even though the burdens of the treatment outweigh the expected benefits.
185	☐ I do not want any medical treatment except what is necessary to provide feeding and hydration and what is necessary to relieve pain and discomfort.
186	☐ I do not want any medical treatment (including artificial feeding and hydration), except what is necessary to relieve pain and discomfort.
187	☐ I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatments.
188	☐ In addition to the above, I want: (If you have additional desires, complete in your own words). (attach additional sheets if needed).
189	**Donation of Organs at Death**
190	☐ Upon my death, I do NOT wish to donate my organs.
191	☐ Upon my death, I give any needed organs, tissues, or parts.
192	☐ Upon my death, I give the following organs, tissues, or parts only:
193	My anatomical gift is for the following purposes: (select ALL that apply) ☐ Transplant ☐ Therapy ☐ Research ☐ Education
	Final Requests
194	Final Arrangements (Choose ALL that apply):
195	☐ I want to be cremated at: (Location)

Revocable Living Trust Agreement (continued)		
196	☐ I want to be buried at: (Location)	
197	☐ I want to be embalmed	
198	☐ Type of Casket	
199	☐ Type of marker	
200	☐ Epitaph	
201	Flowers ☐ YES ☐ NO	
202	☐ Type of ceremony and size:	
203	**Primary Physician**	
204	I designate the following physician as my primary physician: Name Address City, State, Zip Phone	
205	If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician: Name Address City, State, Zip Phone	
If additional space is needed, number and insert below.		
	OTHER WISHES	
206	**Spouse's health care directive information**	
207	Name of spouse trustor	
208	Social Security Number	Birth date (mm/dd/yyyy)

Revocable Living Trust Agreement (continued)			
209	*List information about the person you wish to designation as your Agent to Make Health Care Decisions (Attorney in Fact), when you are unable to make your own decisions:*		
210	Name of Agent		
211	Address		
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229	☐ Make a disposition of a part or parts of my body as an Anatomical Gift for educational or scientific purposes.		
230	☐ Direct the disposition of my remains (burial, cremation, etc.).		
231	*Specify the length of this Health Care Power of Attorney:*		
232	☐ Unlimited Duration, until revoked by me at a later date.		
233	☐ This Power of Attorney expires on _____. (Fill in date)		
234	*Specify when your AGENT's authority becomes effective:*		

Revocable Living Trust Agreement (continued)	
235	☐ My AGENT's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.
236	☐ My AGENT's authority to make health care decisions for me takes effect immediately.
237	**Desires Regarding Life Sustaining Treatment**
238	*Choose ONE of the following paragraphs: 239, 240, 241 or 242. If 239 is selected, mark each sub-paragraph that applies.*
239	Choose all that apply: ☐ I do not want my life to be prolonged and I do not want life-sustaining treatments if I have an incurable and irreversible condition that will result in my death within a relatively short time. ☐ I do not want my life to be prolonged and I do not want life-sustaining treatments if I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness. ☐ I do not want my life to be prolonged and I do not want life-sustaining treatments if the risks and burdens of treatment would outweigh the expected benefits. ☐ I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.
240	☐ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards, even though the burdens of the treatment outweigh the expected benefits.
241	☐ I do not want any medical treatment except what is necessary to provide feeding and hydration and what is necessary to relieve pain and discomfort.
242	☐ I do not want any medical treatment (including artificial feeding and hydration), except what is necessary to relieve pain and discomfort.
243	☐ I want my AGENT to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatments.
244	☐ In addition to the above, I want: (If you have additional desires, complete in your own words). (attach additional sheets if needed).
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247	☐ Upon my death, I give any needed organs, tissues, or parts.
248	☐ Upon my death, I give the following organs, tissues, or parts only:
249	My anatomical gift is for the following purposes: (select ALL that apply) ☐ Transplant ☐ Therapy ☐ Research ☐ Education
250	**Final Requests**
251	Final Arrangements (Choose ALL that apply):
252	☐ I want to be cremated at: (Location)

Revocable Living Trust Agreement (continued)	
253	☐ I want to be buried at: (Location)
254	☐ I want to be embalmed
255	☐ Type of Casket
256	☐ Type of marker
257	☐ Epitaph
258	Flowers ☐ YES ☐ NO
259	☐ Type of ceremony and size:
260	**Primary Physician**
261	I designate the following physician as my primary physician: Name Address City, State, Zip Phone
262	If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician: Name Address City, State, Zip Phone
If additional space is needed, number and insert below.	
263	OTHER WISHES
ACKNOWLEDGEMENT and SIGNATURE	
264	Do you want us to prepare your Revocable Living Trust papers? ☐ YES ☐ NO
265	Do you want us to make copies and conform the papers for filing or recording? ☐YES ☐ NO
266	Date Living Trust is to become effective ☐ Upon signing ☐ On (date)

267	This Acknowledgement must be signed by Grantor (and Joint Grantor, if any).

I (We), acknowledge that the information provided by me in this Workbook is true and accurate to the best of my knowledge. I further acknowledge that I am going to do my own living trust agreement and want the **POCKET LAWYER®** Document Preparation Service to assist me by performing certain document preparation services, according to my instructions. I will be solely responsible for the information contained in these documents and will have the opportunity to review the completed documents before they are filed, recorded, etc. I understand that the **POCKET LAWYER** Document Preparation Service does not render legal advice or legal services and is acting solely at my direction and pursuant to my decisions. I further understand that I have the right to handle my own legal matters and act as my own attorney, but that the advice of an attorney may be necessary. The **POCKET LAWYER** encourages attorney participation and will provide a list of attorney referrals, at my request.

I hereby relieve the **POCKET LAWYER** from any liability whatsoever, regarding preparation of these documents, and agree to hold them harmless from any damages I may suffer and understand that my sole relief is limited to the return of any fee paid for the preparation of these documents.

By typing my name, I declare that I have read and agree with the above paragraphs.

Signature	Date
Print name	
Signature	Date
Print name	