VOLS
VOLUNTEERS of LEGAL SERVICE

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SENIOR LAW PROJECT

LIFE PLANNING DOCUMENTS INTAKE QUESTIONNAIRE

The VOLS Senior Law Project helps low-income older adults (age 60+) who live in New York City obtain wills and advance directives free of charge. If you are filling this form out on a computer, please download it first, THEN type in your answers. Save as you go.
Email completed form to seniorlaw@volsprobono.org, fax to (347) 274-2797, or mail to 40 Worth Street, Suite 829, New York, NY 10013. Call (347) 521-5704 with any questions.

ARE YOU THE APPLICANT? ☐ YES ☐ NO *If no, please state your name, phone # / email, and relationship to the applicant. If you are a social worker/case worker, please also state your organization:*

_____

NAME OF APPLICANT (& LEGAL NAME IF DIFFERENT): _____

_____ **D.O.B.:** _____________

PRONOUNS: ☐ SHE/HER ☐ HE/HIM ☐ THEY/THEM ☐ OTHER: _____

RACE/ETHNICITY: _____ **PREFERRED LANGUAGE:** _____

STREET ADDRESS: _____ **APT / FLOOR # (if any)**: _____

CITY: _____ **STATE**: _____ **ZIP CODE:** _____

EMAIL: _____ **PHONE #:** _____

MARITAL STATUS: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ NEVER MARRIED ☐ WIDOWED ☐ LONG TERM PARTNER / DOMESTIC PARTNERSHIP
If legally married, spouse's name and address: _____

_____

HOW MANY LIVING CHILDREN DO YOU HAVE? _____ *Please provide their information below:*

Name: _____ Age: _____

Address: _____

Name: _____ Age: _____

Address: _____

Name: _____ Age: _____

Address: _____

Name: _____ Age: _____

Address: _____

Have you, your partner, or any member of your close family served in the **US MILITARY?** ☐ YES ☐ NO

APPLICANT'S MONTHLY INCOME: (*for eligibility purposes only*) SS/SSDI $_____ SSI $_____

PENSION $_____ EMPLOYMENT $_____ VA BENEFITS $_____ OTHER $ _____

ASSETS: CHECKING $ _____ RETIREMENT ACCOUNT(S) $ _____

SAVINGS $ _____ VALUE OF INVESTMENTS $ _____

DO YOU RENT OR OWN YOUR PRIMARY RESIDENCE? ☐ RENT ☐ OWN ☐ OTHER (*please explain*):

_____

DESCRIBE YOUR PRIMARY RESIDENCE: ☐ NYCHA ☐ SECTION 8 ☐ OTHER SUBSIDIZED HOUSING
☐ RENT-STABILIZED APARTMENT ☐RENT-CONTROLLED APARTMENT ☐MARKET RENT APARTMENT
☐ CONDO/HOUSE ☐ NURSING HOME ☐ ASSISTED LIVING ☐ MENTAL HEALTH FACILITY ☐ SRO
☐ MITCHELL-LAMA CO-OP ☐ HDFC CO-OP ☐ PRIVATE CO-OP ☐ SHELTER

☐ OTHER: _____

OF OTHER ADULTS IN YOUR HOUSEHOLD: _____ # OF MINORS IN YOUR HOUSEHOLD: _____

ASIDE FROM YOUR PRIMARY RESIDENCE, DO YOU OWN ANY ADDITIONAL PIECE(S) OF PROPERTY IN NEW YORK OR ANYWHERE ELSE, SUCH AS A HOUSE OR CO-OP APARTMENT? ☐ YES ☐ NO

If yes, please list the address, type of property, and estimated value: _____

_____

DO YOU RECEIVE ANY OF THE FOLLOWING PUBLIC BENEFITS? (*check all that apply*)

☐ SCRIE ☐ DRIE ☐ SNAP ☐SCHE ☐DHE ☐MEDICAID ☐ OTHER: _____

IF YOU BELIEVE THAT YOU LIVE IN AN INCOME-RESTRICTED CO-OP OR RENT-CONTROLLED/STABILIZED APARTMENT, ARE YOU INTERESTED IN SPEAKING WITH AN ATTORNEY ABOUT YOUR ELIGIBILITY TO FREEZE YOUR RENT THROUGH SCRIE / DRIE? ☐ YES ☐ NO ☐ NOT SURE

The following questions about disability are for reasonable accommodation purposes only:
DO YOU HAVE A DISABILITY THAT IMPACTS YOUR ABILITY TO…? (*check all that apply*)
☐ READ ☐ SIGN YOUR NAME ☐ WRITE YOUR INITIALS ☐ HEAR ☐ SPEAK ☐ NONE OF THE ABOVE

DO YOU HAVE A DISABILITY THAT LIMITS YOUR ABILITY TO TRAVEL TO APPOINTMENTS?
☐ YES ☐ NO *If yes, which of the following modes of transport can you use? Check all that apply:*
☐ PUBLIC TRANSPORTATION ☐ I CAN DRIVE / SOMEONE CAN DRIVE ME ☐ ACCESS-A-RIDE

☐ TAXI / CAR SERVICE ☐ I CANNOT TRAVEL AT ALL ☐ OTHER: _____

WHICH DOCUMENT(S) ARE YOU SEEKING TO OBTAIN?

Please check all that apply.

☐ 1. **POWER OF ATTORNEY**: Allows you to choose somebody to carry out property, financial, and legal decisions for you (*e.g. to pay your bills, sign a lease for you, or appear in court on your behalf*), even if illness or disability prevents you from doing so yourself.

☐ 2. **HEALTH CARE PROXY:** Allows you to choose somebody to make medical decisions for you if you are ever too sick to communicate with a doctor.

☐ 3. **LIVING WILL**: Allows you to list what kind of medical care you would want, or would not want, at the end of your life (*e.g. "I do want tube feeding" or "I do not want tube feeding"*).

☐ 4. **LAST WILL & TESTAMENT:** Allows you to choose who will get your money and property after you pass away.

☐ 5. **CONTROL OF REMAINS FORM:** Allows you to choose somebody to handle your funeral arrangements, and to leave instructions about what will happen to your body (*ie., "I would like to be buried" or "I would like to be cremated")*.

☐ **OTHER DOCUMENT(S):** _____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT YOU BELIEVE WE SHOULD HAVE:

_____

Please do your best to complete the following sections for each of the documents that you are seeking to obtain, as this information will be necessary to include in your life-planning documents. If you are unsure how to answer any of these questions, please write "Not Sure." You will be able to discuss these items with a VOLS attorney during your intake call.

POWER OF ATTORNEY

Please complete this section only if you are seeking to obtain a Power of Attorney document.

DO YOU CURRENTLY HAVE A POWER OF ATTORNEY? ☐ YES ☐ NO

You must name at least one agent whom you would like to appoint to make legal, financial, and property decisions on your behalf. You may name more than one Agent. You may choose one or more backup agents.

Agent #1: _____ Address: _____

_____

Agent #2: _____ Address: _____

_____

Backup Agent #1: _____ Address: _____

_____

Backup Agent #2: _____ Address: _____

_____

HEALTH CARE PROXY

Please complete this section only if you are seeking to obtain a Health Care Proxy document.

DO YOU CURRENTLY HAVE A HEALTH CARE PROXY? ☐ YES ☐ NO

You must name at least one agent whom you would like to appoint to make health care decisions on your behalf. It is recommended that you also choose a backup agent, but it is not required.

Agent #1: _____ Phone #: _____

Address: _____

Backup Agent: _____ Phone #: _____

Address: _____

LIVING WILL

Please complete this section only if you are seeking to obtain a Living Will.

DO YOU CURRENTLY HAVE A LIVING WILL? ☐ YES ☐ NO

IF A DOCTOR DETERMINES THAT YOU ARE UNLIKELY TO RECOVER, DO YOU WANT THE DOCTOR TO LIMIT YOUR MEDICAL TREATMENT (e.g. ARTIFICIAL NUTRITION/HYDRATION)? ☐ YES ☐ NO

LAST WILL & TESTAMENT

Please complete this section only if you are seeking to obtain a Last Will & Testament.

DO YOU CURRENTLY HAVE A WILL? ☐ YES ☐ NO

EXECUTOR: *In your Last Will & Testament, you will choose an "Executor" to make sure that your wishes are carried out after you pass away. You can choose anyone (age 18+) to be your Executor, like a family member, partner, friend or neighbor. If you choose someone who is not a US citizen, please notify us, as there may be restrictions on their ability to act as your Executor.*

You must choose at least one Executor of your will. You may name up to two Executors, and up to two back-ups (If you do not choose a back-up, and your Executor is unable to perform, the County Public Administrator will be your Executor).

Executor #1: _____ Address: _____

_____

Executor #2: _____ Address: _____

_____

Backup #1: _____ Address: _____

_____

Backup #2: _____ Address: _____

_____

NEXT OF KIN: *Please follow the instructions below to provide information about your next of kin.*

Do you have a living SPOUSE and/or living CHILD(REN)? ☐ YES ☐ NO

If YES, *make sure that you have already provided their name(s) and address(es) earlier on this form, and then* ***skip down this page to*** **ASSETS & BENEFICIARIES.** *If* NO, *continue to the following questions* ➡

Do you have any living GRANDCHILD(REN)? ☐ YES ☐ NO

If YES, *please* ***STOP*** *and provide their information in the spaces below. If* NO, *continue* ➡

Do you have any living PARENT(S)? ☐ YES ☐ NO

If YES, *please* ***STOP*** *and provide their information in the spaces below. If* NO, *continue* ➡

Do you have any living SIBLING(S)? ☐ YES ☐ NO

If YES, *please* ***STOP*** *and provide their information in the spaces below. If* NO, *continue* ➡

Do you have any living NIECE(S) / NEPHEW(S)? ☐ YES ☐ NO

If YES, *please* ***STOP*** *and provide their information in the spaces below. If* NO, *continue* ➡

Do you have any OTHER LIVING FAMILY MEMBERS? ☐YES ☐ NO

If YES, *please* ***STOP*** *and provide their information in the spaces below.*

Please attach an additional paper if necessary.

Name: _____ Age: _____ Relationship: _____

Address: _____

Name: _____ Age: _____ Relationship: _____

Address: _____

Name: _____ Age: _____ Relationship: _____

Address: _____

ASSETS & BENEFICIARIES: *Below, please share how you would like to distribute your property in your will. Please be specific, but please note that you will also be able to discuss your wishes with your volunteer attorney.* ***If you name somebody whom you haven't listed elsewhere in this form, please also state their address and relationship to you.*** *Please attach an additional paper if necessary.*

Asset	**A. Who would you like to leave this asset to when you pass away?**	**B. Who would you like to leave this asset to if the person listed in column A dies before you do?**
Your primary residence (if you own it):		
Any additional piece of property that you own:		
The physical contents of your home:		
The contents of your bank account:		
Any specific object(s) like jewelry, art, heirlooms or antiques (make sure to name the object):		

CONTROL OF REMAINS FORM

Please complete this section only if you are seeking to obtain a Control of Remains Form.

DO YOU CURRENTLY HAVE A CONTROL OF REMAINS FORM? ☐ YES ☐ NO

You must name at least one agent whom you would like to handle your funeral arrangements after you pass away. It is recommended that you also choose a backup agent, but it is not required.

Agent #1: _____ Phone #: _____

Address: _____

Backup Agent: _____ Phone #: _____

Address: _____

MY PREFERENCE IS FOR MY BODY TO BE:

☐ BURIED ☐ CREMATED ☐ DONATED ☐ OTHER: _____

HAVE YOU ENTERED INTO A PRE-FUNDED, PRE-NEED AGREEMENT WITH A FUNERAL HOME?

☐ YES ☐ NO *If yes, name of funeral home:* _____

_____

PLEASE PROVIDE ANY ADDITIONAL INFORMATION ABOUT HOW YOUR REMAINS SHOULD BE HANDLED:

_____

_____

PLEASE READ AND SIGN BELOW:

THE PURPOSE OF THIS QUESTIONNAIRE IS TO DETERMINE YOUR ELIGIBILITY FOR OUR SERVICES, TO COLLECT INFORMATION TO HELP US MATCH YOU WITH A VOLUNTEER ATTORNEY, AND TO COLLECT INFORMATION THAT A VOLUNTEER LAWYER MAY USE IF YOUR CASE IS ACCEPTED FOR REPRESENTATION. THIS QUESTIONNAIRE DOES NOT REPRESENT AN OFFER OF LEGAL REPRESENTATION NOR IS IT INTENDED AS LEGAL ADVICE.

I HAVE READ AND UNDERSTAND THE PURPOSE OF THIS QUESTIONNAIRE, AND I GIVE VOLS PERMISSION TO RELEASE MY INFORMATION TO A VOLUNTEER LAWYER.

SIGNATURE: _____ DATE: _____

WHAT HAPPENS NEXT?

1. Upon receipt of this completed questionnaire, VOLS will contact the applicant for an initial intake call, to gather any additional information and confirm that we will be able to take the case.
2. If we are able to take the case, we will find a volunteer attorney to work with the applicant.
3. Once we have matched the applicant with a volunteer attorney, we will notify the applicant. This attorney will then reach out to the applicant and start drafting the documents. They will send drafts of the documents to VOLS for review and approval.
4. Once the finished documents have been approved by VOLS, the volunteer attorney will schedule a date for the applicant to sign (or "execute") the documents.
5. After the execution ceremony, the applicant will take home completed life-planning documents!