

ESTATE (PROBATE) INTAKE QUESTIONNAIRE

Rincker Law, PLLC
c/o Cari B. Rincker, Esq.
301 N. Neil Street, Suite 400
Champaign, IL 61820
Phone (217) 531-2179
Fax (217) 531-2211
cari@rinckerlaw.com
www.rinckerlaw.com

1. **NAME OF DECEDENT:** _____

PERMANENT RESIDENCE AT TIME OF DEATH (Prior to Nursing Home or Hospital): _____

CITY: _____ COUNTY: _____

STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ DATE OF DEATH: _____

SOCIAL SECURITY NUMBER: _____

WAS DECEDENT EVER ON MEDICAID? (Please circle one) YES NO

WAS DECEDENT EVER ON MEDICARE? (Please circle one) YES NO

2. **LOCATION OF WILL, IF ANY:** _____

DATE OF WILL: _____

LOCATION OF CODICIL, IF ANY: _____

DATE OF CODICIL: _____

3. **PERSONAL REPRESENTATIVE (NAMED IN WILL OR PROPOSED):** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

TELEPHONE: _____

RELATIONSHIP TO DECEDENT: _____

ALTERNATE PERSONAL REPRESENTATIVE (NAMED OR PROPOSED): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

TELEPHONE: _____

RELATIONSHIP TO DECEDENT: _____

4. **BENEFICIARIES OR HEIRS AT LAW:**

DECEDENT'S SPOUSE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

DECEDENT'S CHILDREN:

CHILD # 1: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 2: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 3: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 4: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

CHILD # 5: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

OTHER BENEFICIARIES (INCLUDE LIVING SIBLINGS AND LIVING PARENTS):

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

RELATIONSHIP TO THE DECEDENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

RELATIONSHIP TO THE DECEDENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____

RELATIONSHIP TO THE DECEDENT: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

5. ASSETS:

SAFE DEPOSIT BOX: YES: _____ NO: _____

LOCATION: _____

REAL ESTATE:

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ DOD VALUE: _____

HOW TITLED: _____

HOMESTEAD: YES: _____ NO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ DOD VALUE: _____

HOW TITLED: _____

HOMESTEAD: YES: _____ NO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY: _____ DOD VALUE: _____

HOW TITLED: _____

HOMESTEAD: YES: _____ NO: _____

STOCKS AND BONDS:

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

DATE OF DEATH VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

DATE OF DEATH VALUE: _____

NAME OF COMPANY: _____

TYPE OF SECURITY: _____

HOW TITLED: _____

LOCATION OF CERTIFICATE: _____

DATE OF DEATH VALUE: _____

BANK ACCOUNTS:

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

BANK NAME: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

MONEY MARKET ACCOUNTS OR CERTIFICATES OF DEPOSIT:

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

NAME OF INSTITUTION: _____

ACCOUNT NUMBER: _____

HOW TITLED: _____

DATE OF DEATH VALUE: _____

U.S. GOVERNMENT SAVINGS BONDS (E, EE, H):

HOW TITLED: _____

LOCATION OF BONDS: _____

TO BE CASHED: YES _____ NO _____

IF YES, NAME OF TRANSFEREE: _____

DATE OF DEATH VALUE: _____

MORTGAGES AND NOTES (RECEIVABLE):

MORTGAGOR 1: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TERMS OF OBLIGATION: _____

DATE OF DEATH VALUE: _____

MORTGAGOR 2: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TERMS OF OBLIGATION: _____

DATE OF DEATH VALUE: _____

INSURANCE ON DECEDENT'S LIFE:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARIES NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

ANNUITIES:

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

COMPANY NAME: _____ POLICY #: _____

BENEFICIARY NAMED: _____

LOCATION OF POLICY: _____

DATE OF DEATH VALUE: _____

VEHICLES:

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

DATE OF DEATH VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

DATE OF DEATH VALUE: _____

MODEL: _____ YEAR: _____

HOW TITLED: _____

LOCATION OF TITLE: _____

DATE OF DEATH VALUE: _____

MISCELLANEOUS PERSONAL PROPERTY:

6. DEBTS

Please list all debts owed by the decedent, including the amount owed, at the time of their death. (Example of debts would be credit cards, automobile loans, home loans, doctor's bills, etc.)

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$ _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$ _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$ _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$ _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$ _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$ _____

CREDITOR: _____

CREDITOR'S ADDRESS: _____

TYPE OF DEBT: _____ AMOUNT OWED: \$ _____

7. OTHER QUESTIONS:

ARE ANY OF DECEDENT'S CHILDREN DISABLED? YES or NO

IF YES, PLEASE LIST THE CHILD'S NAME AND NATURE OF DISABILITY: _____

8. DOCUMENTS NEEDED BY THIS OFFICE:

_____ DEATH CERTIFICATE

_____ COPY OF PAID FUNERAL BILL

_____ COPIES OF ANY REAL ESTATE DEEDS

_____ COPIES OF ANY VEHICLE TITLES

_____ COPIES OF ANY BILLS

_____ LAST WILL AND TESTAMENT (IF ONE EXISTS) (**ORIGINAL NEEDED**)

PERSONAL REPRESENTATIVE

1. Has applicant ever been charged with, arrested for or convicted of a felony? _____

If "yes" was answered, please give date and complete details _____

2. Has applicant ever been charged with, arrested for or convicted of any other crimes? _____

If "yes" was answered, please give date and complete details _____

3. Does applicant have any physical disabilities? _____

If "yes" was answered, please explain _____

4. Will any physical disability listed above affect ability to serve as personal representative?

5. Has applicant ever been treated for the following?

a. Mental condition _____

b. Alcohol _____

c. Drugs _____

d. Other _____

Nature of Condition _____

If "yes" was answered to any of the above, please state date, time, location of treatment,
and name of physician or professional involved _____

Under penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true,
to the best of my knowledge and belief.

Print Name: _____