Office: 2801 Buford Hwy NE, Suite 510 • Atlanta, Georgia 30329 Phone: (404) 736-6066 • Fax: (404) 736-6057 • EstateLawAtlanta.com *Mailing Address: 2480 Briarcliff Road NE, Suite 6-345, Atlanta, Georgia 30329*

**PROBATE INTAKE QUESTIONNAIRE**

Please complete the following form. If you are unsure what to put or whether a question applies to your situation, you may leave it blank. Additionally, when giving information about a minor, please provide the email and phone number for the child’s guardian instead of the child.

# BASIC PERSONAL INFORMATION

Today’s Date:


### 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? ❏ Yes ❏ No

WAS DECEDENT EVER ON MEDICARE? ❏ Yes ❏ No

### LOCATION OF WILL, IF ANY:

DATE OF WILL: LOCATION OF CODICIL, IF ANY: DATE OF CODICIL:

# ESTATE REPRESENTATION / EXECUTOR / ADMINISTRATOR

**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:

# BENEFICIARIES OR HEIRS AT LAW:

**DECEDENT’S SPOUSE:** ADDRESS: CITY: STATE: ZIP CODE: DATE OF BIRTH: SOCIAL SECURITY #: TELEPHONE:

**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 #:

**NAME:** ADDRESS: CITY: STATE: ZIP CODE: TELEPHONE: RELATIONSHIP TO THE DECEDENT: DATE OF BIRTH: SOCIAL SECURITY #:

# 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:

NAME OF INSTITUTION: ACCOUNT NUMBER: HOW TITLED: DATE OF DEATH VALUE:

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

HOW TITLED: LOCATION OF FONDS: TO BE CASHED: ❏ Yes ❏ No

IF YES, NAME OF TRANSFEREE:

DATE OF DEATH VALUE:

# MORTAGES 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 DECENT’S LIFE:

COMPANY NAME: POLICY #: BENEFICIARIES NAMED: LOCATION OF POLICY: DATE OF DEATH VALUE:

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COMPANY NAME: POLICY #: BENEFICIARIES NAMED: LOCATION OF POLICY: DATE OF DEATH VALUE:

COMPANY NAME: POLICY #: BENEFICIARIES NAMED: LOCATION OF POLICY:

**ANNUITIES:**

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:

# VEHICLES:

MODEL: YEAR: HOW TITLED: LOCATION OF TITLE: DATE OF DEATH VALUE:

COMPANY NAME: POLICY #: BENEFICIARIES NAMED: LOCATION OF POLICY: DATE OF DEATH VALUE:

MODEL: YEAR: HOW TITLED: LOCATION OF TITLE: DATE OF DEATH VALUE:

COMPANY NAME: POLICY #: BENEFICIARIES NAMED: LOCATION OF POLICY: DATE OF DEATH VALUE:

MODEL: YEAR:

HOW TITLED: LOCATION OF TITLE: DATE OF DEATH VALUE:

# MISCELLANEOUS PERSONAL PROPERTY:

**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: $:

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# OTHER QUESTIONS:

ARE ANY OF DECEDENT’S CHILDREN DISABLED? ❏ Yes ❏ No

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

# 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:

HAS APPLICANT EVER BEEN CHARGED WITH, ARRESTED FOR OR CONVICTED OF A FELONY? ❏ Yes ❏ No

IF “YES” WAS ANSWERED, PLEASE GIVE DATE AND COMPLETE DETAILS:

HAS APPLICANT EVER BEEN CHARGED WITH, ARRESTED OR CONVICTED OF OTHER CRIMES? ❏ Yes ❏ No

IF “YES” WAS ANSWERED, PLEASE GIVE DATE AND COMPLETE DETAILS:

DOES APPLICANT HAVE ANY PHYSICAL DISABILITIES? ❏ Yes ❏ No

IF “YES” WAS ANSWERED, PLEASE EXPLAIN:

WILL ANY PHYSICAL DISABILITY LISTED ABOVE AFFECT ABILITY TO SERVE AS PERSONAL REPRESENTATIVE? ❏ Yes ❏ No

HAS APPLICANT EVER BEEN TREATED FOR THE FOLLOWING?

|  |  |  |
| --- | --- | --- |
| MENTAL CONDITION | * Yes
 | * No
 |
| ALCOHOL | * Yes
 | * No
 |
| DRUGS | * Yes
 | * No
 |
| OTHER | * Yes
 | * No
 |

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

PRINT NAME:

DATE:

You may submit this intake form by email to Sarah@EstateLawAtlanta.com. If you would prefer not to send your documents by email, please call the office at (404)736-6066 to arrange a secure transfer.