



CONFIDENTIAL PLANNING FORM

Appointment Date: _____ Time: _____ Location: _____

*** ALL INFORMATION CONTAINED IN THIS FORM IS CONFIDENTIAL AND PROTECTED BY ATTORNEY-CLIENT PRIVILEGE. ***
Completing this prior to your appointment will enable us to spend more time during the meeting to answer your questions and help you identify solutions to your concerns. Call us if you have questions.

Are you completing this form on behalf of someone else? [] Yes, Your Name: _____

Your Tel # _____ Email: _____ Relationship to Client: _____

PERSONAL AND FAMILY

Client Name _____ Age: _____ DOB: _____ [] US citizen?

Occupation: _____ [] retired [] employed SSN: _____

Address: _____ City _____ County _____ Zip _____

Home Tel # _____ Other Tel # _____ E-mail address _____

Does anyone else live in the home? If yes, please describe: _____

[] Married, Date: _____ [] First [] Other [] Divorced, Date: _____ [] Widow/er [] Single (never married)

Spouse Name _____ Age: _____ DOB: _____ [] US citizen? SSN: _____

Occupation: _____ [] retired [] employed [] deceased: Date of Death: _____

Table with 4 columns: Current Estate Plan, You, Spouse, Date Document Executed. Rows include Power of Attorney, Health Care Directive, Living Will, Will, and Trust.

Health Insurance (Medicare, Blue Cross, Humana, Prescriptions)

Company _____ Policy # _____ Type _____ Premium _____

Long Term Care Insurance

Company _____ Daily Benefit _____ Maximum Benefit \$ _____ Term _____ Premium _____

Health Status

You - current health status: [] Good [] Concern/Problem

Medical condition: _____

Spouse - health status: [] Good [] Concern/Problem

Medical condition: _____

Are there any known problems with memory or understanding? _____

Able to speak? ___ Sign name? ___ Recognize family? ___ Aware of possessions? ___ Able to leave the residence? ___

Do you need daily assistance to perform basic activities? If yes, please explain: _____

[] Bathing [] Dressing [] Getting out of Bed [] Walking [] Eating [] Toileting [] Grooming/Personal Hygiene [] Laundry

[] Using Telephone [] Grocery shopping [] Preparing Meals [] Housework [] Taking Medication [] Managing Money

Level of Care _____ [] Home Caregiver [] Adult Day Care [] Facility _____

Number hours of care per day _____ Rate of Pay \$ _____ Start/Admission Date _____

Who is your primary doctor? _____ Specialty _____ Telephone _____

Family

You

Spouse NA

Do you have children: Yes How many? _____ No
 Please specify: joint you step adopted

Yes How many? _____ No
 joint you step adopted

Have Grandchildren? Yes How many? _____ No

Yes How many? _____ No

CHILDREN (BIOLOGICAL, ADOPTED, OR STEP), OR OTHER BENEFICIARY

Name: _____ Male Female Age: _____ Date of Birth: _____
Address: _____ **Phone:** _____
 Child of: joint you spouse adopted foster child Other relation _____
 Student Employed: Occupation: _____
 Single Married first second other - how long? _____ Spouse's name: _____ Occupation: _____
 Children: none How many? _____ Ages: _____
 Special needs/considerations: _____
 Potential problems/hardships/issues: _____

Name: _____ Male Female Age: _____ Date of Birth: _____
Address: _____ **Phone:** _____
 Child of: joint you spouse adopted foster child Other relation _____
 Student Employed: Occupation: _____
 Single Married first second other - how long? _____ Spouse's name: _____ Occupation: _____
 Children: none How many? _____ Ages: _____
 Special needs/considerations: _____
 Potential problems/hardships/issues: _____

Name: _____ Male Female Age: _____ Date of Birth: _____
Address: _____ **Phone:** _____
 Child of: joint you spouse adopted foster child Other relation _____
 Student Employed: Occupation: _____
 Single Married first second other - how long? _____ Spouse's name: _____ Occupation: _____
 Children: none How many? _____ Ages: _____
 Special needs/considerations: _____
 Potential problems/hardships/issues: _____

- Rank** the following (High to Low) in order of importance for you currently (**H**=High; **M**=Medium; **L**=Low importance)
- | | |
|---|--|
| _____ Avoid probate | _____ Protect assets from gov't/lawsuits/nursing homes |
| _____ Keep estate matters private | _____ Provide detailed instructions and authority to people I trust to have the care I desire provided for me if I become disabled |
| _____ Keep it simple for my family when something happens to me (disability/death) | _____ Reduce family fighting and maintain harmony |
| _____ Minimize/eliminate taxes | _____ Remain independent and in control of my care and/or assets |
| _____ Protect assets for family after my death (i.e. my spouse's disability or remarriage, my children's divorce, lawsuit, or bankruptcy) | _____ Disinherit a family member |

FINANCIAL INFORMATION

*** It is very important that you indicate in each category ownership and dollar amount separately, as well as total value.***

MONTHLY INCOME (Gross) or BENEFIT:

SOURCE	YOU	SPOUSE	JOINT	TOTAL
Retirement Pension	\$	\$	\$	\$
Social Security	\$	\$	\$	\$
Interest/Dividends	\$	\$	\$	\$
Employment/Wages	\$	\$	\$	\$
Other (VA, SSI, rental)	\$	\$	\$	\$
Total Income	\$	\$	\$	\$

MONTHLY LIVING EXPENSES	YOU	SPOUSE	JOINT	TOTAL
How Much You Spend Each Month to Live	\$	\$	\$	\$
How Much You Spend on Heat	\$	\$	\$	\$
How Much You Spend on Medical Needs	\$	\$	\$	\$

ASSET INFORMATION, as of: _____ (date) - Please provide total value amount for each type of asset and who owns.

TYPE OF ASSET (provide statements)	YOU	SPOUSE	JOINT	TOTAL
Cash , Checking, Savings, CD's, Money Market & Cash Management Accounts	\$	\$	\$	\$
Investments /Broker-held Accounts (not including cash) and Mutual Fund Accounts	\$	\$	\$	\$
Bonds: bonds you hold (not in brokerage accounts)	\$	\$	\$	\$
Stocks: you hold (not in brokerage accounts)	\$	\$	\$	\$
Annuities: \$=original amount Date invested =month/year purchased CV=current value	\$ _____ date _____ CV _____	\$ _____ date _____ CV _____	\$ _____ date _____ CV _____	\$ _____ date _____ CV _____
Retirement Accounts: IRA, 401K, 403B, SEP	\$	\$	\$	\$
Life Insurance: Death Benefit: Cash Value:	D.B. \$ C.V. \$	D.B. \$ C.V. \$		
Primary Residence (value per property tax bill)	\$	\$	\$	\$
Real estate: other (timeshare, land, rental)	\$	\$	\$	\$
Vehicles: automobile, motorcycle, boats, etc.	\$	\$	\$	\$
Total Assets	\$	\$	\$	\$

OTHER ASSETS NOT LISTED:

TYPE	YOU	SPOUSE	JOINT	TOTAL
Personal Property (antiques, jewelry, art, rare coins)	\$	\$	\$	\$
Other: Do you own a gun? <input type="checkbox"/>	\$	\$	\$	\$
Total Value	\$	\$	\$	\$

LIABILITIES (Debt):

TYPE	YOU	SPOUSE	JOINT	TOTAL
Mortgage Payment \$_____ Loan Balance:				\$
Other Debt (credit cards, loans)				\$
Total Debt				\$

What would completing your estate plan help you accomplish? _____

ASSET TRANSFERS

➤ Have either **you or your spouse either transferred or gifted away assets in the last 60 months** made any large gifts (\$1,500+ in value) to family or charity, placed any property into trust, transferred any real estate or other property for less than fair market value, or removed or added names to joint accounts, or **closed an account**? If so, please list the dates, type of account closed with the closing balance, and where the assets were transferred on a **separate sheet**.

<i>(Please check "Yes" or "No" for your answer)</i>	Yes	No
Is anyone (other than your spouse) dependent upon you for support? If yes, <i>please describe</i> :		
Are you or spouse making payments pursuant to a divorce or property settlement order?		
If you are a widow and filed a federal estate tax or a state death tax return, <i>please furnish a copy</i> .		
Have you or spouse ever been "admitted" in a hospital for more than 3 consecutive nights? <i>When?</i>		
Have you ever stayed in a in a nursing home, rehab center, or an assistant living facility? If yes, <i>please provide dates and facility</i> :		
Are you currently the beneficiary of anyone else's trust or estate planning documents?		
Do you have pets that you wish to give away or provide for upon your death?		
Do any of your children or grandchildren receive government support or benefits (i.e., SSI, SSDI, Medical Assistance, Veterans VA benefits)?		
Have you prepaid for funeral/burial?		

MILITARY SERVICE

Are you a veteran? _____ Are you the surviving spouse of a Wartime Veteran? _____
 Period of Service: WWII (1941-1946) Korean Conflict (1950-1955) Vietnam Era 1961/64-1975
 Branch of Service: _____ Dates of Service _____ Discharge Status? _____
 Disability Rating: _____ Current Benefits _____

ADDITIONAL INFORMATION

- A. Would you like to be an organ donor? _____
- B. Would you like to be buried or cremated? _____
- C. SPECIAL CONCERNS OR CONSIDERATIONS THAT YOU WANT TO DISCUSS WITH ATTORNEY DOUGLAS:

- D. How did you hear about us? Referred by _____ Website Workshop Other: _____

Form completed by: Signature _____ *Date:* _____

During your appointment, our attorney will review this questionnaire with you and answer your questions. This summary is designed to help you list **ALL** the property that you own, how titled, and its worth. In lieu of this checklist, you may also submit a detailed financial statement. Should you decide to retain the Douglas Law Office to assist you with your estate planning, you will have to provide more particular information about your assets, including such things as your daily living expenses, bank statements, account numbers, and specific beneficiary designations. It can be a tedious process to gather and organize all of this information; so, don't worry. Do your best. It is appreciated by all.