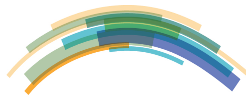

TAKACS MCGINNIS
ELDER CARE LAW

** Confidential Planning Information (for Married Couple) **

for use by Takacs McGinnis Elder Care Law, PLLC

Your appointment with us is: ____

Our address is 201 Walton Ferry Road, Hendersonville, Tennessee.

These questions pertain to the persons, married couple, for whom we are planning.

Please call us at (615) 824-2571 if you have any questions or concerns about completing this form.

Date:______________________________ **Referred by:**__________________________________

1. Personal Information

	Spouse 1	Spouse 2
Spouse 1: / **Spouse 2:**	______________________	______________________
Address:	______________________	______________________
	______________________	______________________
Phone:	______________________	______________________
Email:	______________________	______________________
Date of birth:	______________________	______________________
Place of birth	______________________	______________________
SSN:	______________________	______________________
U. S. citizen?:	☐ Yes ☐ No	☐ Yes ☐ No
Veteran?:	☐ Yes ☐ No	☐ Yes ☐ No
	If Yes, dates of service:	If Yes, dates of service:
	Branch of service:	Branch of service:

Date and place of marriage:____

Wife's maiden name:____

Place Where You Live	**Spouse 1/ When?**	**Spouse 2 / When?**
Single-family home or apartment	☐ /	☐ /
Same, but you need assistance	☐ /	☐ /
Retirement living community	☐ /	☐ /
Assisted-living facility	☐ /	☐ /
Nursing home	☐ /	☐ /
Other	☐ /	☐ /
County of Residence:		

2. Information About Your Health (Spouse 1)

a. What medical or health problems do you currently have?

b. Who is your current primary physician?
Name:
Address:
Phone Number:

c. What medical problems have you had in the past?

d. When were you last in the hospital, and why?

e. Please attach a list of the drugs you are currently taking to this workbook.

Information About Your Health (Spouse 2)

a. What medical or health problems do you currently have?

b. Who is your current primary physician?
Name:
Address:
Phone Number:

c. What medical problems have you had in the past?

d. When were you last in the hospital, and why?

e. Please attach a list of the drugs you are currently taking to this workbook.

3. Children

Name: ______________________ | Name: ______________________
Address: ______________________ | Address: ______________________
______________________ | ______________________
DOB: ______________________ | DOB: ______________________
Phone: ______________________ | Phone: ______________________
Email: ______________________ | Email: ______________________
Spouse: ______________________ | Spouse: ______________________

Name: ______________________ | Name: ______________________
Address: ______________________ | Address: ______________________
______________________ | ______________________
DOB: ______________________ | DOB: ______________________
Phone: ______________________ | Phone: ______________________
Email: ______________________ | Email: ______________________
Spouse: ______________________ | Spouse: ______________________

Name: ______________________ | Name: ______________________
Address: ______________________ | Address: ______________________
______________________ | ______________________
DOB: ______________________ | DOB: ______________________
Phone: ______________________ | Phone: ______________________
Email: ______________________ | Email: ______________________
Spouse: ______________________ | Spouse: ______________________

a. Do you have any dependents (someone who depends on you, in whole or in part, for their support)?

☐ Yes ☐ No

If yes, who?:____

b. Are any of your children or other family members receiving Supplement Security Income, Social Security Disability; or, whether or not receiving any benefits, is blind or has any major disabilities?

☐ Yes ☐ No

If yes, who?:____

4. Resources *(please use additional sheet of paper as needed)*

a. Monthly Income (SS, VA, pension, employment)

Source	Spouse 1	Spouse 2
Social Security:		
Pension (source)______:		
Other (source) ________:		
Interest / Dividends		
Total:		

b. Real Estate You Own

Address	Owner(s)	Tax Value	Mortgage	Date Acquired

c. Other Assets: Bank accounts, CDs, annuities, stocks, retirement plans, and the like

Type of Asset	Company Name	How Titled?	Beneficiary	Value

d. Life Insurance (including any policies through your employer)

Life Insurance	Policy 1	Policy 2	Policy 3
Company Name			
Policy Owner			
Insured			
Beneficiary			
Death Benefit (face value)			
Current Cash Value (if any)			
Loan Against Policy (if any)			

e. Large items of personal property you own (cars, boats, RVs, farm equipment, etc.)

Personal Property (Item)	Value

5. Health Insurance and Long-Term Care Insurance

a. Health Insurance	**Spouse 1**	**Spouse 2**
Traditional Medicare	☐	☐
Medicare Supplemental Insurance	☐	☐
Medicare Advantage Plan *(e.g. Healthspring)*	☐	☐
Retiree Health Insurance	☐	☐
TRICARE for Life	☐	☐
Other (please describe)	☐	☐

b. Long-Term Care Insurance

Spouse 1: Yes☐ No ☐ / Spouse 2: Yes☐ No ☐

6. Final Arrangements

Prepaid funeral, burial, cremation? Spouse 1: Yes☐ No ☐ / Spouse 2: Yes☐ No ☐

7. Estate Planning *(If you have estate planning documents, please bring them with you to the meeting)*

	Spouse 1	**Spouse 2**
Durable Power of Attorney Name of your Attorney-in-Fact:	☐ Yes ☐ No	☐ Yes ☐ No
Health Care Power of Attorney/Advance Care Plan Name of your Health Care Agent:	☐ Yes ☐ No	☐ Yes ☐ No
Will	☐ Yes ☐ No	☐ Yes ☐ No
Revocable Living Trust	☐ Yes ☐ No	☐ Yes ☐ No

8. Gifts and Transfers

Have either of you given away any money or property within the past 60 months? ☐ Yes ☐ No

If Yes, what did you give away, when, and to whom?:

9. Notes, Comments, Explanation

10. Summary of your concerns, questions, worries