



**** Confidential Planning Information (for Individual) ****

for use by Takacs McGinnis Elder Care Law, PLLC

Your appointment with us is _____

These questions pertain to the person for whom we are planning. Please do your best, but don't worry if you don't have all of the information. Please call us if you need help.

Date: _____

Referred by: _____

1. Personal Information

Your Name

Your Spouse

Address: _____

Date of death: _____
 or
 Date of divorce: _____

Phone: _____

Place of death: _____

Email: _____

Date of birth: _____

Birth date: _____

Birth place: _____

SSN: _____
 US citizen?: Yes No
 Veteran?: Yes No
 Dates of service: _____
 Branch of service: _____

SSN: _____
 Yes No
 Yes No
 Dates of service: _____
 Branch of service: _____

Wife's maiden name: _____

Date and place of marriage: _____

Place Where You Live	When?
Single-family home or apartment	
Same, but you need assistance	
Independent living community:	
Assisted-living or memory care facility:	
Nursing home:	
Other:	
County of Residence:	

2. Information About Your Health

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

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

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

d. Please attach a list of the drugs you are currently taking to this workbook (or list them below).

3. Important Contact Information

Your Primary Care Physician	Your Financial Advisor/Broker
Name: _____	Name: _____
Specialty: _____	Company: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Email: _____	Email: _____
_____	_____

4. Children

Name: _____
Address: _____
DOB: _____
Phone: _____
Email: _____
Spouse: _____

Name: _____
Address: _____
DOB: _____
Phone: _____
Email: _____
Spouse: _____

Name: _____
Address: _____
DOB: _____
Phone: _____
Email: _____
Spouse: _____

Name: _____
Address: _____
DOB: _____
Phone: _____
Email: _____
Spouse: _____

Name: _____
Address: _____
DOB: _____
Phone: _____
Email: _____
Spouse: _____

Name: _____
Address: _____
DOB: _____
Phone: _____
Email: _____
Spouse: _____

a. Your primary contact person(s):

Name: _____
Address: _____
Phone: _____
Email: _____

Name: _____
Address: _____
Phone: _____
Email: _____

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

Yes No If yes, who?: _____

c. 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?: _____

5. Resources

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

Source	Amount
Social Security:	
Pension:	
Other:	
Total:	

b. Real Estate (please bring your deeds with you for us to copy)

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 Is It Titled?	Beneficiary	Value

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

Policy Details	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

6. Health Insurance and Long-Term Care Insurance

a. Health Insurance	(Check if Yes)
Traditional Medicare	<input type="checkbox"/>
Medicare Supplemental Insurance	<input type="checkbox"/>
Medicare Advantage Plan (e.g. Healthspring)	<input type="checkbox"/>
Retiree Health Insurance	<input type="checkbox"/>
TRICARE for Life	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

b. Long-Term Care Insurance

Yes No

7. Final Arrangements

Prepaid funeral, burial, cremation? Yes No

8. Estate Planning

Do you have any of the following documents?	
Durable Power of Attorney Name of your Attorney-in-Fact:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Power of Attorney/Advance Care Plan Name of your Health Care Agent:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have estate planning documents, please bring them with you to the meeting.

9. Gifts and Transfers

Have 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?:

10. Notes, comments, explanation:

11. Summary of your concerns, questions, and worries: