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 _____

These questions pertain to the persons (the married couple) 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

	Spouse 1	**Spouse 2**
Name:		
Address:		
Phone:		
Email:		
Birth date:		
Birth place:		
SSN:		SSN:
US citizen?:	☐Yes ☐No	☐Yes ☐No
Veteran?:	☐Yes ☐No	☐Yes ☐No
	Dates of service:_____	Dates of service:_____
	Branch of service:_____	Branch of service:_____

Wife's maiden name: _____

Date and place of marriage:_____

Place Where You Live	**Spouse1:When?**	**Spouse2: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 (Spouse 1)

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 (Spouse 1)

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

4. Information About Your Health (Spouse 2)

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).

5. Important Contact Information (Spouse 2)

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

6. 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. Your primary contact person(s):

Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Email:		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?:______________________________

7. Resources

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

Source	Spouse 1	Spouse 2
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

8. 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☐

9. Final Arrangements

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

10. Estate Planning

Do you have any of the following documents?	**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

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

11. 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?:

12. Notes, comments, explanation:

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