



**\*\* 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: \_\_\_\_\_

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	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:	
<b>Total:</b>	

**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 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**

<b>a. Health Insurance</b>	<b>(Check if Yes)</b>
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**

<b>Do you have any of the following documents?</b>	
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:**