TAKACS MCGINNIS
ELDER CARE LAW

** 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
Name:	____________		____________
Address:	____________	Date of death: or Date of divorce:	____________
	____________		____________
County:	____________	Place of death:	____________
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 ______________________________

2. Your primary contact person(s): Landline☐ Cell ☐ Text ☐ Email ☐ Mail ☐ Fax ☐ Other ________

Name:	____________	Name:	____________
Address:	____________	Address:	____________
	____________		____________
Phone:	____________	Phone:	____________
Email:	____________	Email:	____________

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

3. Children

Name: ________________
Address: ________________
____
DOB: ________________
Phone: ________________
Email: ________________
Spouse: ________________

Name: ________________
Address: ________________
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Email: ________________
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Email: ________________
Spouse: ________________

Name: ________________
Address: ________________
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DOB: ________________
Phone: ________________
Email: ________________
Spouse: ________________

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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. 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).

5. Important Contact Information

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

6. 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

7. Health Insurance and Long-Term Care Insurance

a. Health Insurance	**(Check if Yes)**
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

Yes☐ No☐

8. Final Arrangements

Prepaid funeral, burial, cremation? Yes☐ No☐

9. Estate Planning

Do you have any of the following documents?	
Durable Power of Attorney Name of your Attorney-in-Fact:	Yes☐ No☐
Health Care Power of Attorney/Advance Care Plan Name of your Health Care Agent:	Yes☐ No☐
Will – Name of Personal Representative/Executor	Yes☐ No☐
Revocable Living Trust – Name of Trustee	Yes☐ No☐

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

10. 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?:

11. Notes, comments, explanation:

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