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:
City, State and Zip:		or Date of divorce:
County:		Place of death:
Phone:		
Email:		
Birth date:		
Birth place:		
SSN:		SSN:
US citizen?:	◯ Yes ◯ No **Prior Claims?:**	◯ Yes ◯ No **Prior Claims?:**
Veteran?:	◯ Yes ◯ No ◯ Yes ◯ No	◯ Yes ◯ No ◯ Yes ◯ No
	If yes to Veteran, complete page 6	**If yes to Veteran, complete page 6**
	Dates of service:_____	Dates of service:_____
	Branch of service: _____	Branch of service: _____

Spouse's maiden name: _____

Date and place of marriage _____

***2.* Will you be the primary contact? ◯ Yes ◯ No If no, who?** _____

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

Name:	Name:
Address:	Address:
City & Zip:	City & Zip:
Phone:	Phone:

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

3. List all legal Children – adopted, living, or deceased

Name: ______________________
Address: ______________________
City & Zip: ______________________
DOB: ______________________
Phone: ______________________
Email: ______________________
Spouse: ______________________

Name: ______________________
Address: ______________________
City & Zip: ______________________
DOB: ______________________
Phone: ______________________
Email: ______________________
Spouse: ______________________

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Email: ______________________
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Name: ______________________
Address: ______________________
City & Zip: ______________________
DOB: ______________________
Phone: ______________________
Email: ______________________
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. 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:	
City & Zip:		City & Zip:	
Phone:		Phone:	
Email:		Email:	

5. Resources—Failure to disclose assets could completely change the parameters of your plan, therefore it is imperative you disclose everything in writing.

a. ALL Monthly GROSS Income (SS, VA, pension, employment, and rental)

Source	Amount
Social Security:	
Pension:	
Other:	
Other:	
Total:	

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

Address	Owner(s)	Tax Value	Mortgage	Date Acquired

c. All 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	☐
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 ◯

(Bring summary of coverage)

Name of Company: _____

Length of Policy: _____

Benefit Amount: _____

7. Final Arrangements

Prepaid funeral, burial, cremation? Yes ◯ No ◯

8. Estate Planning -*If you have estate planning documents, please bring them with you to the meeting.*

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 ◯

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:

11. Checklist of items to bring to appointment:

☐ Durable Power of Attorney
☐ Healthcare Power of Attorney/Advance Directive/Living Will
☐ Will/Handwritten Will
☐ Trust (Revocable or Irrevocable) and any amendments
☐ DD214 (any and all Veterans papers)
☐ Deed(s) to your property (all)
☐ Long Term Care Insurance Policy
☐ Other: _____

Addendum

Military Service Information:

- Branch of Service: _____
- Dates of Service (Month/Year if possible):
  - Entered active service: _____
  - Released from active service: _____
- Type of Discharge: _____
  - If discharge is not an Honorable Discharge, please describe in note field below the circumstances surrounding the discharge.
- Did you retire from military service (Y/N): ____
- Were you medically separated or discharged (Y/N): _____
- Did you serve in Vietnam or in the territorial waters (12 nautical miles) of Vietnam (Y/N): ____
- Were you ever exposed to atomic bomb testing (Y/N): ____ * ("Oath of secrecy" that atomic veterans were required to take has been rescinded by the 1996 repeal of the Nuclear Radiation Secrecy Agreement Act; veterans are free to discuss their participation in atomic testing)
- Did you serve in the Korean DMZ area (Y/N): ____

Veterans Affairs Information:

- Have you previously filed a claim with the VA (Y/N): _____
- Do you have any currently pending claims with the VA (Y/N): ____
- Have you, or anyone on your behalf, filed an "intent to file" form with the VA (Y/N): ____
- Did you suffer any physical or mental injuries during your military service (Y/N): ____
  - If yes, please describe: _____
    _____
    _____
- Do you have a service connected rating with the VA (Y/N): ____
  - If yes, what is your current rating (%): ____
  - If yes, how long have you had this current rating (years): ____
  - If yes, when did you receive your initial rating (year): ____
- Do you currently have an individual appointed as your VA representative (Y/N): ____

Checklist Items:

- Copy of DD-214
- Military Medical records related to any service-connected injuries
- Official Military Personnel File (OMPF) ** (If you don't have this, you can request it, medical records and a copy of your DD-214 at this website: https://vetrecs.archives.gov/VeteranRequest/home.html#BasicInformation)

Notes:

_____
_____
_____
_____
_____
_____