

**\*\* 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?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Prior Claims?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Veteran?: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes to Veteran, complete page 6</b>	<b>If yes to Veteran, complete page 6</b>
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: _____
Name: _____ Address: _____ City & Zip: _____ DOB: _____ Phone: _____ Email: _____ Spouse: _____	Name: _____ Address: _____ City & Zip: _____ DOB: _____ Phone: _____ Email: _____ Spouse: _____
Name: _____ Address: _____ City & Zip: _____ DOB: _____ Phone: _____ Email: _____ Spouse: _____	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**

<b>Your Primary Care Physician</b>	<b>Your Financial Advisor/Broker</b>
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:	
<b>Total:</b>	

**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**

<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**

Name of Company: \_\_\_\_\_

Yes  No

Length of Policy: \_\_\_\_\_

**(Bring summary of coverage)**

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.**

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

**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:

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