Confidential Planning Information

Date:_____ Referred by:_____

1. Personal Information

Husband:	_____	**Wife:**	_____
Address:	_____	Date of birth:	_____
	_____	Place of birth:	_____
Phone:	_____	SSN:	_____
Email:	_____	U. S. citizen?:	Yes ☐ No
County:	_____	Veteran?:	☐ Yes No
Date of birth:	_____	Address:	Same as Husband
Place of birth:	_____		☐ Different:
SSN:	_____		_____
U. S. citizen?:	Yes ☐ No		_____
Veteran?:	Yes ☐ No	Phone:	_____

Marriage Information

Date:

Contact Information

If not you, who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?:

_____

Name:
Address:

Phone:
Email:
Spouse:
Children:

Name:
Address:

Phone:
Email:
Spouse:
Children:

2. Children

Name:
Address:

Phone:
Email:
Spouse:
Children:

Name:
Address:

Phone:
Email:
Spouse:
Children:

Name:
Address:

Phone:
Email:
Spouse:
Children:

Name:
Address:

Phone:
Email:
Spouse:
Children:

Do you have any dependents (that is, someone who depends on you, in whole or in part, for their support)? ☐ Yes No
If yes, wh o?:

Are any of your children receiving Supplement Security Income, Social Security Disability; or, if not, has any major disabilities? Yes ☐ No
If yes, who?:

3. Information About Your Health

Husband:

1. What medical or health problems do you currently have?

2. What medical problems have you had in the past?

3. Please list all of the medications you are currently taking:

Medication	Why Are You Taking This Drug?

4. Does your family have a history of health problems (for example, heart disease, cancer, or Alzheimer's disease)? Describe:

5. Name of your personal physician(s):

Name:

Address:

City/State:

Medical specialty:

Telephone #:

Name:

Address:

City/State:

Medical specialty:

Telephone #:

Wife:

1. What medical or health problems do you currently have?

2. What medical problems have you had in the past?

3. Please list all of the medications you are currently taking:

Medication	Why Are You Taking This Drug?

4. Name of your personal physician(s):

Name:

Address:

City/State:

Medical specialty:

Telephone #:

Name:

Address:

City/State:

Medical specialty:

Telephone #:

4. Functional Limitations and Support

The term "activities of daily living" refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help in order to cope, from either other human beings or mechanical devices (such as a walker or wheelchair) or both.

Why do we want this information? Measurement of the activities of daily living is critical because the more assistance people need with their daily activities, the more likely are they to be admitted to a nursing home or other living arrangement; to use paid home care; to use hospitals and doctors; and to die sooner rather than later.

Place an X in the box that most applies for each activity.

Husband:

Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			

Instrumental Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

	Place Where You Live	**Since When?**
	Single-family home	
☐	Same, but someone assists you there with above activities	
☐	Apartment or retirement living community	
☐	Assisted-living facility	
☐	Other:	
☐	Nursing home	

List the names of all persons who provide assistance or caregiving for you:

_____

Wife:

Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			

Instrumental Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

	Place Where You Live	**Since When?**
	Single-family home	
☐	Same, but someone assists you there with above activities	
☐	Apartment or retirement living community	
☐	Assisted-living facility	
☐	Other:	
☐	Nursing home	

List the names of all persons who provide assistance or caregiving for you:

_____

5. Estate Planning

Do you have any of the following documents?	Husband	Wife
Durable Power of Attorney	Yes☐ No	Yes ☐ No
Health Care Power of Attorney	Yes☐ No	Yes ☐ No
Living Will	Yes ☐ No	Yes ☐ No
Will	Yes ☐ No	Yes ☐ No
Revocable Living Trust	☐ Yes ☐ No	☐ Yes ☐ No

Place an X in the box that applies. Please bring the existing documents with you to our meeting.

For the questions below, please complete *only* if the above documents are not in place or you expect to make changes to these documents as a part of our planning process.

There is a section to be completed for each of you (Husband and Wife).

Note: Please read all of the choices before selecting one. (If you aren't sure what you want to do, you don't have to make any choices right now.) We will discuss your choices at our meeting.

Husband:

Upon my death, I want to give
Everything to my wife, if she survives me, otherwise to my children in equal shares **OR**
Alternative #1
☐ Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached age _____
Alternative #2
☐ Everything to my children and to my deceased spouse's children in equal shares.
Alternative #3
☐ I want to make bequests different from those above.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount
No	

Whom do you want to serve as your executor? Please give name and full addresses for a first choice, and for an alternate second choice.

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

If you want a trust set up for your children or grandchildren or anyone else, please give name and full addresses for a first choice trustee, and for an alternate second choice.

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Decision Making

Health Care

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? (List in order of priority)

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Do you want to be an organ donor? ☐ Yes No ☐ Don't know

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference? ☐ Yes N No
If yes, what religion are you?:_____

Legal and Financial

If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal, and financial affairs? (List in order of priority)

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?:
Yes ☐ No ☐ Don't know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

☐ No restrictions, I trust my attorney-in-fact to make the right decision.

My restrictions are:_____

Wife:

Upon my death, I want to give
Everything to my husband, if he survives me, otherwise to my children in equal shares
OR
Alternative #1
☐ Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached age _____
Alternative #2
☐ Everything to my children and to my deceased spouse's children in equal shares.
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Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

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1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

If you want a trust set up for your children or grandchildren or anyone else, please give name and full addresses for a first choice trustee, and for an alternate second choice.

1. Name:

Address:

City/State:

Relationship:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Decision Making

Health Care

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? (List in order of priority)

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Do you want to be an organ donor? ☐ Yes No ☐ Don't know

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference? Yes ☐ No
If yes, what religion are you?_____

Legal and Financial

If you were unable to carry out your financial business, who would you want to take care of your legal, business, personal, and financial affairs? (List in order of priority)

1. Name:

Address:

City/State:

Relationship:

Telephone #:

2. Name:

Address:

City/State:

Relationship:

Telephone #:

Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?:
Yes☐ No ☐ Don't know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?
No restrictions, I trust my attorney-in-fact to make the right decision.

☐ My restrictions are:_____

Gifts and Transfers
This question applies to both Husband and Wife.

Have either of you made any gifts or transfers, greater than $500.00, to any individuals within the last sixty (60) months? ☐ Yes No

If yes, please furnish the indicated information for each gift or transfer:

Name:		Name:	
Date of gift:		Date of gift:	
Item:		Item:	
Value:		Value:	
Name:		Name:	
Date of gift:		Date of gift:	
Item:		Item:	
Value:		Value:	

6. Resources

Monthly Income

Do not list interest or dividend income.

Source	Husband	Wife	Joint
Social Security:			
Pension:			
Other:			
Total:			

A. Personal Residence

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____ Purchase Price: $_____

Current Value: $_____ Tax-Appraised Value: $_____

Mortgage Company:

Mortgage Balance:

B. Other Real Estate

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax-Appraised Value: _____

Mortgage Company: _____

Mortgage Balance: _____

Address of property: _____

Names as they appear on deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax-Appraised Value: _____

Mortgage Company: _____

Mortgage Balance: _____

Other Assets

These are your bank accounts, CDs, annuities, stocks, retirement plans, and the like.

Type of Asset: _____

Name of Company: _____

Value: $_____

How is it titled?:_____

_____

Type of Asset:_____

Name of Company: _____

Value: $_____

How is it titled?: _____

_____

Type of Asset: _____

Name of Company: _____

Value: $_____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Type of Asset: _____

Name of Company: _____

Value: _____

How is it titled?: _____

Total Value of Assets on this Page: $_____

List all life insurance.

Company Name: _____
Owner: _____
Insured: _____
Beneficiary: _____
Death Benefit (face value): _____
Cash surrender value: _____
Loan against policy (if any): _____

Company Name: _____
Owner: _____
Insured: _____
Beneficiary: _____
Death Benefit (face value): _____
Cash surrender value: _____
Loan against policy (if any): _____

Company Name: _____
Owner: _____
Insured: _____
Beneficiary: _____
Death Benefit (face value): _____
Cash surrender value: _____
Loan against policy (if any): _____

Personal Property.

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.) or any valuable collections (antiques, coins and stamps, guns, etc.):

Personal Property (Item)	Value

Do either or both of you have a prepaid funeral or burial? Yes ☐ No

If yes, describe the arrangements:

Husband:_____

Wife:_____

Other Insurance

Please complete the following health insurance information as it applies to both of you:

Husband:

Medicare

Traditional Medicare Fee-for-Service? Yes ☐ No

OR

Medicare HMO, PSO, PPO, Private Plan? X☐ Yes☐ No

Company: _____

Medicare Supplement ("Medigap")

Company: _____

Type (Plan A through J):_____

Medicare Prescription Drug Discount Card

Company: _____

Employer Retiree Health Plan

Company: _____

Private Health Insurance

Company: _____

Long Term Care Insurance

Company: _____

Daily Benefit Amount:_____

Length of Coverage:_____

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)

Company: _____
Type: _____

Company: _____
Type: _____

Company: _____
Type: _____

Wife:

Medicare
Traditional Medicare Fee-for-Service? Yes ☐ No
OR
Medicare HMO, PSO, PPO, Private Plan? ☐ Yes ☐ No
Company: _____

Medicare Supplement ("Medigap")
Company: _____
Type (Plan A through J):_____

Medicare Prescription Drug Discount Card
Company: _____

Employer Retiree Health Plan
Company: _____

Private Health Insurance
Company: _____

Long Term Care Insurance
Company: _____
Daily Benefit Amount:_____
Length of Coverage:_____

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)
Company: _____
Type: _____

Company: _____

Type: _____

Company: _____

Type: _____

7. Monthly Expenses

Item	Amount
Property tax	
Home maintenance and upkeep	
Homeowners insurance	
Utilities (gas, electric, water & sewer, security)	
Residential facility	
Private health care services	
Telephone	
Cable television	
Auto operation (gas and maintenance)	
Auto insurance	
Clothing	
Groceries and other household	
Hair cuts, personal grooming	
Laundry and cleaning	
Checking account charges/bank fees	
Newspapers and magazines	
Recreation, vacation, entertainment	
Health insurance (such as Medicare supplement)	
Unreimbursed medical expense (such as for drugs)	
Life insurance	
Charitable contributions	
Other: _____	
Other: _____	
Total Monthly Expenses:	

Anticipated maintenance needs to homestead (examples: roof, windows, painting, foundation repair, driveway, etc.)

Item	Cost
Roof	
Plumbing	
Total	

8. Money You Owe

Creditor's Name	Amount Owed
Total	

9. Public Benefits and Community Services

In addition to Social Security and Medicare, are you receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, TennCare, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group services, property tax relief, home weatherization, and drug company discount card programs.

☐ Yes No

If yes, please list them below:

Provider	Form of assistance

10. Wrap-up and Signature

Please add anything else you would like to tell us:

_____

_____

_____

_____

The above information is true and correct to the best of my knowledge and belief.

_____

Husband (Your signature, or the signature of your attorney-in-fact)

_____

Wife (Your signature, or the signature of your attorney-in-fact)