ELDER LAW at
AHRENS DEANGELI
LAW GROUP

Confidential Planning Workbook

Planning for a Single Individual
For Use by Ahrens DeAngeli Law Group LLP

Call us at (208) 639-7799 if you have any questions about completing this form.

Please bring copies of your most recent financial/bank statements, current estate planning documents and real property deeds to the meeting.

1. Personal Information

Full Legal Name: _____

Name you want us to call you: _____

Date of Birth: _____/_____/_____ Age: _____

Are You A Veteran? ☐ **Yes** ☐ **No**

If widowed, was your Spouse a veteran? ☐ **Yes** ☐ **No**

Was Spouse injured in service? ☐ **Yes** ☐ **No**

Did Spouse receive a VA benefit? ☐ **Yes** ☐ **No**

If yes, Spouse's Full Legal Name: _____

Date of Birth: _____/_____/_____ Date of Death _____/_____/_____

Date of Marriage: _____ # of Years Married _____

2. Your Contact Information

Street Address: _____

City, State and Zip Code: _____

Home Phone: _____ Cell. Phone: _____

E-mail address: _____

Does anyone live with you? ☐ **Yes** ☐ **No**

If yes, who lives with you? _____

3. Income/Assets

Gross Monthly Income (*Do not list interest or dividend income.)*

Source	
Social Security:	
Pension (From Previous Employer):	
IRA Distribution:	
VA:	
Other:	
Total:	

Assets: Use your best estimate of each asset's value, assuming you could cash it in or sell it today at a fair price. Disregard what you paid for the asset.

Source	**Value**	**Debt on Asset**
Your Home		
2nd Home/Cabin/Land		
Checking:		
Savings:		
CDs:		
Investments (stocks/bonds, etc.):		
Annuities:		
IRA/401k:		
Cash Value Life Insurance		
Prepaid Funeral Plan:		
Car 1:		
Car 2:		
Other Vehicles:		
Other _____:		
Other _____:		
Total:		

4. Real Estate

(Please bring a copy of the deed(s) on all real property you own to our meeting)

A. **Personal Residence**

Address of property: _____

Names as they appear on deed: _____

Current Value: _____ Tax-Appraised Value: _____

B. **If you own Other Real Estate/Land/Rental Properties, etc.**

Address of property: _____

Names as they appear on deed: _____

Current Value: _____ Tax-Appraised Value: _____

5. Monthly Expenses:

(Please note monthly expenses. If you have annual figures, divide by 12 months)

HOUSING EXPENSES	
Home Care/Asst. Living/Nursing Home	
Mortgage/Rent	
2nd Mortgage	
Homeowner's Association Dues	
Property tax	
Homeowners insurance	
HEALTH INSURANCE EXPENSES	
Part D (Drug) Insurance Premium	
Health Insurance Premium	
Dental/Vision Premiums/Expenses	
LTC Insurance Premium	
Unreimbursed medical expense (prescriptions, ect.)	
Life insurance premiums	
Other monthly expenses: _____	
Total Monthly Expenses:	

6. Money You Owe (credit cards, outstanding medical bills, etc.)

Creditor's Name	Total Amount Owed
Total	

7. Money Owed to You (loans, promissory notes, mortgages, etc.)

Debtor's Name	Total Amount Owed
Total	

8. Gifts and Transfers Have you made any gifts or transfers to any individuals within the last sixty (60) months? Gifts and transfers include money, property or goods given away or sold for less than fair market value and include charitable contributions. *(Use additional sheet if necessary)*

☐ **Yes** ☐ **No** **<u>If yes, please furnish the indicated information for each gift or transfer:</u>**

Name:		**Name:**	
Month/Year:		**Month/Year:**	
Item:		**Item:**	
Value:		**Value:**	
Name:		**Name:**	
Month/Year:		**Month/Year:**	
Item:		**Item:**	
Value:		**Value:**	

9. Insurance *(Please complete the following health insurance information as it applies to each of you.)* Place an X in the box, if applicable.

Type of Insurance/Coverage	Company Name	Premium Amount
Traditional Medicare (physician and hospital – Part A/B)?		
Medicare Supplement?		
Medicare Advantage/Replacement Plan?		
Medicare Prescription (Part D)?		
Employer Retiree Health Plan?		
Type of Insurance/Coverage	**Company Name**	**Premium Amount**
Private Health Insurance?		
Long Term Care Insurance (LTC) Contracts? *Please bring copies of LTC Contract Policy.*		
Annuity Contracts? *Please bring copies Annuity Policy.*		
Other Type (cancer, accidental, hospital supp.)?		

10. Information About Your Health

A. **Do you have any health problems associated with long term care?**

_____

_____

_____

B. **Name of your personal physician(s):**

Name: _____

Medical specialty: _____ Telephone #: _____

Address: _____

Name: _____

Medical specialty: _____ Telephone #: _____

Address: _____

11. Functional Limitations and Support

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

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			
Taking Medications			

Are you getting assistance with the above activities? ☐ **Yes** ☐ **No**

12. Your Children

Child #1 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Child #2 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Child #3 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Child #4 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Child #5 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Are any of your children or grandchildren disabled? ☐ Yes ☐ No

If yes, please list their names: _____

13. Estate Distribution Wishes

Do you have any of the following documents?		
Financial Power of Attorney	**☐ Yes**	**☐ No**
Health Care Power of Attorney	**☐ Yes**	**☐ No**
Living Will	**☐ Yes**	**☐ No**
Last Will and Testament	**☐ Yes**	**☐ No**
Revocable Living Trust	**☐ Yes**	**☐ No**
Community Property Agreement	**☐ Yes**	**☐ No**

Upon my death, I want to give
☐ Everything to my children in equal shares
OR

☐ I want to make bequests different from those above. If you check this box, please explain in writing your estate distribution wishes here:

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

Beneficiary	Item/Amount

14. Administration of Financial Matters:

If you needed assistance with making financial decisions, who would you want to make financial decisions for you? (List in order of priority).

A. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

B. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

C. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

15. Health Care Decision Making

If you were in the hospital and unable to make decisions for yourself, who would you want to make medical decisions for you? (List in order of priority).

A. **Name (First M. Last):** _____
Address: _____

Relationship:_____ **Telephone #:**_____

B. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

C. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

16. Advisors

	Name	Firm	Phone #
Accountant/Tax Advisor			
Financial Advisor			
Insurance Agent			

We contact our clients' professional advisors and let them know that we are working with you. We will assume that is ok with you unless you tell us otherwise.

17. Legal Proceedings

Are you a party to any court proceeding? ☐ **Yes** ☐ **No**
If yes, please describe: _____

18. Anything else you would like us to know?

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

_____
Your signature, or the signature of your attorney-in-fact