



ESTATE PLANNING INFORMATION

This is a **confidential** estate planning worksheet designed to gather the basic information I need to begin the process of preparing your estate plan. I will use this information to make recommendations about the structure of your estate in light of possible medical and long-term care needs, potential long-term disabilities, and eventually death. The information that you provide will be strictly confidential. In order to represent your interests adequately in these matters, I must have the most detailed, up-to-date information as possible.

I realize that some of the information requested in this worksheet may not apply to your situation; you should fill out only those portions of the worksheet that apply to you. I also realize that you might not be able to supply all of the information requested in a perfectly accurate or up-to-date form. If information is currently unavailable, or if locating the information will take a great deal of time, I can begin our discussions with the information that you do provide and locate the other items at a later date.

Please complete this form prior to our meeting. If possible, please return the form before our conference. If I am able to review the information it contains prior to our meeting, the discussion can immediately focus on the substance of your estate planning. If you have not been able to send the completed form to me before our meeting, please bring it with you to our appointment.

IF YOUR APPOINTMENT IS TO DISCUSS MATTERS REGARDING SOMEONE OTHER THAN YOURSELF, COMPLETE THIS FORM WITH THAT PERSON'S INFORMATION.

If assistance is needed to complete the form, please call me at (612) 751-7519.

CONFIDENTIAL LEGAL PLANNING INFORMATION

PERSONAL DATA:

Name _____ Spouse (if applicable) _____

Address _____ Address _____

County of Residence _____ County of residence _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

Email address _____ Email address _____

Birth date _____ Age _____ Birth date _____ Age _____

Employer _____ Employer _____

Retirement date _____ Retirement date _____

Veteran Yes No

Veteran Yes No

U.S. Citizen Yes No

U.S. Citizen Yes No

Soc. Sec. No. _____

Soc. Sec. No. _____

Type of residence:

Type of residence:

- Rent home/apartment
- Own home
- Assisted Living
- Nursing home/Care facility

- Rent home/apartment
- Own home
- Assisted Living
- Nursing home/Care facility

Date of hospital/nursing home admission, if applicable _____

Has either spouse been in a hospital or nursing home or combination of both for 30 days or more, since October 1, 1989? Yes No. If so, please list date of admission: _____

Have you completed an Asset Assessment form for the county? Yes No

If so, please bring a copy of the form with you to our conference. **IF YOUR FAMILY MEMBER IS IN A NURSING HOME OR IS RECEIVING HOME HEALTH SERVICES, PLEASE ALSO COMPLETE THE NURSING HOME SUPPLEMENT AT THE END OF THIS DOCUMENT.**

Were you referred to my office? If so, by whom? _____

In your household:

Who pays the bills? _____

Who balances the checkbook? _____

Who decides how to invest? _____

If applicable, have you and your spouse signed a pre-marital agreement? Yes No. If so, please provide a copy of the agreement.

FAMILY DATA:

Date of marriage: _____

Previously married? Yes No

Children:

Name: _____

Birth date: _____

Spouse: _____

Address: _____

Home Phone: _____

Work Phone: _____

Names of grandchildren and dates of birth: _____

Name: _____

Birth date: _____

Spouse: _____

Address: _____

Home Phone: _____

Work Phone: _____

Names of grandchildren and dates of birth: _____

Name: _____

Birth date: _____

Spouse: _____

Address: _____

Home Phone: _____

Work Phone: _____

Names of grandchildren and dates of birth: _____

Do you or your spouse have children by a previous marriage? Self: Yes No

Spouse: Yes No

If so, please list names _____

Do you or your spouse have any children who died leaving children of their own? Yes No

If so, please explain _____

Do you or your spouse have any children who are permanently and totally disabled? Yes No

If so, please list name and disability. _____

Does the child receive either SSI or Social Security Disability benefits? _____

Do you have special financial or care giving responsibility for any family members (aging parents, disabled children or grandchildren, or other relatives)? _____

Does anyone to whom you may be leaving part of your estate require any help or protection in managing money or other property? _____

Have any children received an advance on their inheritance or are any children financially indebted to you? If so, please explain. ? _____

GUARDIAN

If your children are under the age of 18 when you die, and if their other parent is also not alive at that time, then the Court will appoint someone to be the legal guardian of your minor children. Adult children with disabilities may also require guardianship. The guardian will have legal and physical custody of the children until they reach the age of 18. You can appoint someone to serve as the guardian for your minor children.

Name a Guardian and a Successor Guardian (in case the primary guardian is unwilling or unable to serve).

Guardian: _____ Phone Number: _____

Address: _____ Relationship: _____

Successor: _____ Phone Number: _____

Address: _____ Relationship: _____

TRUSTEE

If a trust is included in your estate plan, a “trustee” is the person or entity responsible for managing the assets placed in the trust for the benefit of the trust’s beneficiaries, i.e. your children. The trustee manages the assets according to the terms of the trust and distributes the assets according to the terms of the trust. Note that if you do not establish a trust, your children will inherit at age 18. The trustee can be an individual, bank, trust company, or a combination of these.

Name a Trustee and a Successor Trustee (in case the primary trustee is unable or unwilling to serve).

Trustee: _____ Phone Number: _____

Address: _____ Relationship: _____

Successor: _____ Phone Number: _____

Address: _____ Relationship: _____

HEALTH CARE DIRECTIVE

A health care directive is a useful tool in planning for incapacity and is a recommended part of any estate plan. A health care directive is a written document that makes known your health care wishes to family, friends, and doctors. It allows you to name a health care agent who will have the legal authority to make health care decisions for you – based on your wishes – if you become unable to communicate your health care wishes. It also allows you to specify

your wishes in certain medical situations and your wishes for things such as funeral arrangements and organ donation.

Name a Health Care Agent

Agent Name: _____ Phone Number: _____

Address: _____ Relationship: _____

Alternative Agent (in case the primary agent is unwilling or unable to serve)

Agent Name: _____ Phone Number: _____

Address: _____ Relationship: _____

Note that if you wish, you can name co-agents that have the power to act independently or jointly.

Wishes regarding burial/cremation? _____

Wishes regarding organ donation? _____

Do you have an organ donation designation on your driver's license? Yes No

If in a terminal condition, do you want to direct the agent on the types of therapies and interventions you do or do not want? Yes No

If yes, think about what specific instructions you wish to be included in your Health Care Directive.

Do you have any previous health care directives? Yes No

FINANCIAL POWER OF ATTORNEY

A financial power of attorney is a signed document giving another person (your agent) the legal authority to act on your behalf with respect to your assets. Powers of attorney can be narrowly tailored to specific powers or as broad as giving your agent the power to take all action related to your finances/assets that you would be able to do yourself. A power of attorney is recommended to be included in every estate plan as it is especially useful in planning for incapacity.

With whom do you consult about investment decisions? _____

Who is your insurance agent? _____

Location of important papers: _____

Name an Agent for your Power of Attorney

Agent Name: _____ Phone Number: _____

Address: _____ Relationship: _____

Alternative Agent (in case the primary agent is unwilling or unable to serve)

Agent Name: _____ Phone Number: _____

Address: _____ Relationship: _____

HEALTH AND LONG-TERM CARE INSURANCE: (include name of provider and monthly premiums)

	Husband	Wife
Medicare	_____	_____
Health insurance from employer	_____	_____
Other health insurance	_____	_____
Medicare supplement	_____	_____
Long-term care insurance	_____	_____

TRANSFERS:

Please give details concerning any transfers, gifts, or sales of cash or other property that you or your spouse has made in the last five years, including outright gifts and the additions of someone's name to bank accounts or title to real estate.

Donor	Recipient	Type of asset transferred	Date of transfer	Value of asset at time of transfer

ESTATE PLANNING:

If you have any of the following documents already prepared, please provide the following information:

	<u>Date Made</u>	<u>Location of Original</u>
<u>Will:</u>		
Husband	_____	_____
Wife	_____	_____
<u>Trust:</u>		
Husband	_____	_____
Wife	_____	_____
<u>Power of Attorney:</u>		
Husband	_____	_____
Wife	_____	_____
<u>Living Will/Health Care Declaration:</u>		
Husband	_____	_____
Wife	_____	_____

I am the legally appointed guardian of _____.

I have been appointed under a power of attorney from _____.

I am serving as executor or administrator of an estate _____.

I have or will be signing health care contracts for _____.

I am obligated on other legal contracts or documents _____.

I am involved in a lawsuit regarding _____.

FINANCIAL INFORMATION:

Please read these instructions. They will help you complete this form.

If you do not know the exact value of an asset, a reasonable estimate will be sufficient to allow the planning process to begin.

Some tables below have two columns for you to list the **value** of your assets. If you or your spouse has been admitted to a nursing home or hospital and stayed in one or the other facility or both for more than 30 days, you should list the value of the assets as of the date of the admission to the nursing home or hospital, whichever occurred first. This amount goes under the column titled "**NH Admit.**" In the column titled "**Current: Balance**" you should list the current value of your assets. If you have given any financial information to a social worker, either at the nursing home or at the county, please bring a copy of the information that you gave that person to the conference.

You must clearly state who owns each asset by writing the full name of each person with an ownership interest in the space provided. If you know if the property is owned in joint tenancy, tenancy in common, or with a life estate, please indicate which ownership classification applies. Also, if any bank or other investment account lists beneficiaries, please list the beneficiary names.

IRA accounts and other retirement plans should be listed in the section specified regardless of the investment vehicle. For instance, if you have an IRA invested in a certificate of deposit or an annuity contract, list the IRA under the retirement plan section, and do not list it under the certificate of deposit or annuity sections.

If you find that there is not enough space for a full listing of a particular type of asset on this form, please include additional pages.

Residence

Description of property: _____

Names as they appear on the deed: _____ Date acquired: _____

Current estimated market value: _____

Purchase price: _____

Mortgage balance: _____

Other real property:

1. Description of property: _____

Names as they appear on the deed: _____ Date acquired: _____

Current estimated market value: _____

Purchase price: _____

Mortgage balance: _____

If rental property: Monthly rent received: _____

Monthly property insurance premium: _____

Monthly property tax average monthly maintenance costs: _____

2. Description of property: _____
Names as they appear on the deed: _____ Date acquired: _____
Current estimated market value: _____
Purchase price: _____
Mortgage balance: _____
If rental property: Monthly rent received: _____
 Monthly property insurance premium: _____
Monthly property tax average monthly maintenance costs: _____

Personal Property (Cars, RVs, Boats, etc.)

Description of Property: _____
Purchase price: _____ Name on title: _____
Loan balance: _____ Average monthly maintenance costs: _____

Description of Property: _____
Purchase price: _____ Name on title: _____
Loan balance: _____ Average monthly maintenance costs: _____

Description of Property: _____
Purchase price: _____ Name on title: _____
Loan balance: _____ Average monthly maintenance costs: _____

Contracts for Deed

Addresses for Property Sold:

1. _____
2. _____

Name of Seller(s): _____

Monthly Payment Received: _____

Balance on NH Admit	Current Balance
\$ _____	\$ _____
\$ _____	\$ _____
Total Balance	\$ _____

Bank Accounts

Checking Accounts Bank name	Account # (last 4 digits)	Name of Owner(s)	Interest Rate	Balance on NH Admit	Current Balance
Savings/Money Market Accounts Bank Name	Account # (last 4 digits)	Name of Owner(s)	Interest Rate	Balance on NH Admit	Current Balance
TOTAL:					

Certificates of Deposit

Institution name	Name of Owner(s)	Interest Rate	Balance on NH Admit	Current Balance
TOTAL:				

Treasury Bills

Institution Name

1. _____
2. _____
3. _____
4. _____

Government Bonds

Institution Name	Name of Owner(s)	Beneficiary	Maturity Date	Interest Rate:

Balance on NH Admit	Current Balance
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
Total Balance	\$ _____

Other Bonds & Notes

Institution Name	Name of Owner(s)	Beneficiary	Maturity Date	Interest Rate:

Balance on NH Admit	Current Balance
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
Total Balance	\$ _____

Stocks Corporation Name

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Business Interests

Names of partnerships, sole proprietorships, or corporations in which YOU have an interest

- 1. _____
- 2. _____

Type of business and location and name of owner(s)

- 1. _____
- 2. _____

Estimated value

- 1. _____
- 2. _____

IRAs, Keogh, Profit Sharing, 401K, and other retirement plans

Company Name

- 1. _____
- 2. _____
- 3. _____

Type of Plan or IRA

Balance on NH Admit

Current Balance

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

\$ _____

Total Balance \$ _____

Life Insurance

Company Name	Owner	Insured (if different from owner)	Beneficiary	Face Amount	Cash Surrender Value

If there are any loans on any of the above-mentioned policies, please explain the terms below:

Balance on NH Admit	Current Balance
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
Total Balance	\$ _____

Annuity Contracts

Company Name	Owner	Annuitant (if different from owner)	Beneficiary	Face Amount	Cash Surrender Value

Balance on NH Admit	Current Balance
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
Total Balance	\$ _____

Additional space for other assets

Type of asset and company name:

1. _____

2. _____

Name of Owner(s) and Beneficiaries

1. _____

2. _____

Interest Rate: _____%

Balance on NH Admit	Current Balance
\$ _____	\$ _____
\$ _____	\$ _____
Total Balance	\$ _____

SUMMARY OF ASSETS AND VALUES (from previous pages)

Total Value for each category:

Mortgages

\$ _____

Notes

\$ _____

To whom owed: _____

Car payments

\$ _____

Loans on insurance

\$ _____

Other

\$ _____

Due date: _____

Monthly payment; interest rate: \$ _____ %

Total indebtedness: \$ _____

Financial obligations arising from dissolution of marriage or support actions: _____

Inheritance: Do you or your spouse expect an inheritance? _____

Burial/Funeral Expenses: Have you or your spouse prepaid your funeral expenses? _____

Have you purchased burial plots, caskets, vaults, etc.? _____

How much did you spend for each funeral? \$ _____

The money is invested in: (Check all that apply)

Irrevocable Funeral

Trust Agreement

Life Insurance

MONTHLY INCOME:

	Husband	Wife
Salary and wages:		
Social Security:		
Employment Pension:		
Pension from IRAs, annuities, etc.:		
Rental income:		
Interest and Dividends:		
Other:		
Totals:		

Which sources of income have a benefit for the surviving spouse? _____

MONTHLY SHELTER EXPENSES FOR HOME

Rent or mortgage payments, including principal and interest Real property taxes: \$ _____

Homeowner's Insurance: \$ _____

Required maintenance charges for a cooperative or condominium: \$ _____

Do you pay heating and/or cooling (in addition to rent or association fee, if applicable)? Yes No

If you do not pay heating and/or cooling, do you pay for electricity (in addition to rent or association fee)? Yes

No

If you have prepared or signed any of the following documents, please bring a copy of that document with you to our initial conference, including:

DOCUMENTS NEEDED BY THIS OFFICE:

- LAST WILL AND TESTAMENT
- TRUST AGREEMENTS
- CURRENT POWERS OF ATTORNEY
- CURRENT HEALTH CARE DIRECTIVE OR LIVING WILL
- REAL ESTATE TITLES AND PROPERTY TAX STATEMENTS
- CONTRACTS FOR DEEDS
- PROMISSORY NOTES
- BANK STATEMENTS
- BROKERAGE STATEMENTS (STOCKS, BONDS, SECURITIES)
- LIFE INSURANCE, ANNUITIES, AND LONG-TERM CARE INSURANCE CONTRACTS
- BURIAL OR CREMATION CONTRACTS
- DIVORCE DECREES OR PRE-NUPTIAL AGREEMENTS
- ADMISSION AGREEMENTS TO HOSPITALS AND HEALTH FACILITIES
- ASSET ASSESSMENT FORM, if completed for the county

Legal concerns and goals:

NURSING HOME SUPPLEMENT

Please complete the following if your family member is currently residing in a nursing home:

1. Nursing home: _____
2. Nursing home address: _____
3. Nursing home telephone number: _____
4. Nursing home manager: _____

Date of admission (if family member was admitted first to a hospital and then transferred to a nursing home, state date of admission to hospital): _____

Current case mix classification:

- A
- B
- C
- D

Daily nursing home rate: \$ _____

Long-term care insurance carrier and daily benefit: _____

Cost of nursing home care per month Medical insurance Medications: \$ _____

Physician and other costs: \$ _____

Special expenses, e.g., oxygen, etc., Miscellaneous

\$ _____

\$ _____

\$ _____

\$ _____

Total expenses: \$ _____

Doctor's name, address, and telephone number: _____

Physical and mental condition of family member in nursing home: _____
