

**\*\*Confidential Planning Information\*\***

***For Use by the Hurley Elder Care Law***

These questions pertain to the person (“you”) for whom we are planning. We ask a lot of questions on this form because we need a lot of information about you for our planning for you. Do your best, but don’t worry if some of the information you need to complete this form is not available to you. Please call us at (404) 843-0121 if you have any questions or concerns about completing this form.

Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

**1. Personal Information**

**Your Name:** \_\_\_\_\_

**Your Spouse:** \_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

\_\_\_\_\_

Place of birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of death: \_\_\_\_\_

Email: \_\_\_\_\_

Place of death: \_\_\_\_\_

County: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of birth: \_\_\_\_\_

U. S. citizen?:  Yes  No

Place of birth: \_\_\_\_\_

Veteran?:  Yes  No

SSN: \_\_\_\_\_

U. S. citizen?:  Yes  No

Veteran?:  Yes  No

**List all Marriages:**

Spouse name: \_\_\_\_\_ date: \_\_\_\_\_ Location: \_\_\_\_\_  
How dissolved: \_\_\_\_\_

Spouse name: \_\_\_\_\_ date: \_\_\_\_\_ Location: \_\_\_\_\_  
How dissolved: \_\_\_\_\_

Spouse name: \_\_\_\_\_ date: \_\_\_\_\_ Location: \_\_\_\_\_  
How dissolved: \_\_\_\_\_

If not you, who is your “Contact Person” (the person we should contact for appointments,

for more information about you, etc.)?: \_\_\_\_\_

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

If yes, who?: \_\_\_\_\_

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

If yes, who?: \_\_\_\_\_

**2. Children**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_

Phone (C): \_\_\_\_\_

Phone (W): \_\_\_\_\_

Email: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

SS#: \_\_\_\_\_

Spouse: \_\_\_\_\_

SS#: \_\_\_\_\_

Children: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H): \_\_\_\_\_

Phone (C): \_\_\_\_\_

Phone (W): \_\_\_\_\_

Email: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

SS#: \_\_\_\_\_

Spouse: \_\_\_\_\_

SS#: \_\_\_\_\_

Children: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3**

Name:

Address:

Phone (H):

Phone (C):

Phone (W):

Email:

D.O.B.:

SS#:

Spouse:

SS#:

Children:

D.O.B.:

Name:

Address:

Phone (H):

Phone (C):

Phone (W):

Email:

D.O.B.:

SS#:

Spouse:

SS#:

Children:

D.O.B.:

**4**

Name:

Address:

Phone (H):

Phone (C):

Phone (W):

Email:

D.O.B.:

SS#:

Spouse:

SS#:

Children:

D.O.B.:

Name:

Address:

Phone (H):

Phone (C):

Phone (W):

Email:

D.O.B.:

SS#:

Spouse:

SS#:

Children:

D.O.B.:

**5. Information About Your Health**

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:

Tell us about your parents:

	<b>Your Mother</b>	<b>Your Father</b>
Age at Death:		
Cause of Death:		

5. Name of your personal physician(s):

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State:

\_\_\_\_\_

Medical specialty:

\_\_\_\_\_

Telephone #:

\_\_\_\_\_

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State:

\_\_\_\_\_

Medical specialty:

\_\_\_\_\_

Telephone #:

## 6. 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.

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

<b>Instrumental Activities of Daily Living</b>			
<b>Activity</b>	<b>Need No Help</b>	<b>Need Some Help</b>	<b>Unable to Do At All</b>
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			

	<b>Place Where You Live</b>	<b>Since When?</b>
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Nursing home	

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

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## 7. Estate Planning

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

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.

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.

<b>Upon my death, I want to give</b>
<input type="checkbox"/> Everything to my children in equal shares <b>OR</b>
<u>Alternative #1</u>
<input type="checkbox"/> 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 _____
<u>Alternative #2</u>
<input type="checkbox"/> Everything to my children and to my deceased spouse's children in equal shares.
<u>Alternative #3</u>
<input type="checkbox"/> 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

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: \_\_\_\_\_

Have 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: _____

**8. Resources**

**Monthly Income**

Do not list interest or dividend income.

Source	Amount
Social Security:	
Pension:	
Other:	
<b>Total:</b>	

**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):

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.):

<b>Personal Property (Item)</b>	<b>Value</b>

Do you have a prepaid funeral or burial?  Yes  No

If yes, describe the arrangements: \_\_\_\_\_

**Other Insurance**

Please complete the following health insurance information as it applies:

Medicare

Traditional Medicare Fee-for-Service?       Yes    No      Cost \_\_\_\_\_

OR  
Paid How? \_\_\_\_\_

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

Company: \_\_\_\_\_ Cost \_\_\_\_\_

Paid How? \_\_\_\_\_

Medicare Supplement (“Medigap”)

Company: \_\_\_\_\_ Cost \_\_\_\_\_

Type (Plan A through J): \_\_\_\_\_ Paid How? \_\_\_\_\_

Medicare Prescription Drug Discount Card

Company: \_\_\_\_\_ Cost \_\_\_\_\_

Paid How? \_\_\_\_\_

Employer Retiree Health Plan

Company: \_\_\_\_\_ Cost \_\_\_\_\_

Paid How? \_\_\_\_\_

Private Health Insurance

Company: \_\_\_\_\_ Cost \_\_\_\_\_

Paid How? \_\_\_\_\_

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: \_\_\_\_\_

**9. Monthly Expenses**

<b>Item</b>	<b>Amount</b>
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: _____	_____
<b>Total Monthly Expenses:</b>	_____

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

<b>Item</b>	<b>Cost</b>
_____	_____
_____	_____
_____	_____
_____	_____
<b>Total</b>	_____

**10. Money You Owe**

<b>Creditor's Name</b>	<b>Amount Owed</b>
_____	_____
_____	_____
<b>Total</b>	_____

**11. 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:

<b>Provider</b>	<b>Form of assistance</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## **12. Wrapup 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.

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

### **Please bring the following documents to your meeting:**

Existing Will  
Trust  
Power of Attorneys – Financial and Health Care  
Life Insurance Policy  
Cemetery/Burial Plot Information  
Health Insurance Cards – front and back  
Medicare Card  
Picture ID  
Financial Statements