

**\*\* Confidential Planning Information (for Individual-Short Form) \*\***

*For Use by Lovingood McGuffey, P.C.*

**Your appointment with this office is:** \_\_\_\_\_

Our address is Suite 300, 1300 Cleo Way, Dalton, Georgia 30720.

**These questions pertain to the person (“you”) for whom we are planning.** Please 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 (706) 428-0888 if you have any questions or concerns about completing this form.

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

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

***I. 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 Dates: \_\_\_\_\_

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

U. S. citizen?:  Yes  No

Veteran?:  Yes  No Dates: \_\_\_\_\_

**Marriage Information:**

Date and place of marriage: \_\_\_\_\_

**Children (names, addresses, ages):**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**If you are not living at home:**

Name of facility: \_\_\_\_\_

Date of admission: \_\_\_\_\_

**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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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?: \_\_\_\_\_

**II. Resources**

**Monthly Income**

Do not list interest or dividend income.

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

**Real Estate You Own**

**A. Personal Residence**

Address of property: \_\_\_\_\_

Names as they appear on deed: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Purchase Price: \_\_\_\_\_

Current Value: \_\_\_\_\_ Tax-Appraised Value: \_\_\_\_\_

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 Balance: \_\_\_\_\_

**Other Assets: Your bank accounts, CDs, annuities, stocks, retirement plans, and the like.**

Type of Asset	Company Name	How Is It Titled?	Value

*(Use additional pages as necessary)*

<b>Life Insurance</b>	<b>Policy 1</b>	<b>Policy 2</b>
Company Name		
Owner of Policy		
Insured		
Beneficiary		
Death Benefit (face value)		
Current Cash Value (if any)		
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: \_\_\_\_\_

Have you given away any money or property within the last 60 months?  Yes  No

If you have, what did you give away and when? \_\_\_\_\_

<b>Do you have any of the following documents?</b>	
Durable Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (please specify) _____	

If you have any of the above documents, please bring them with you to the meeting.

Do you have any additional concerns that are not discussed above?:

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We cannot provide accurate advice without accurate information. Lovingood McGuffey and its attorneys will rely on the information you provide to us in this Workbook. By signing below, you are stating that the information provided in this document is true and accurate to the best of your knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date