** Confidential Planning Information (for Individual-Long Form) **

For Use by the Elder Law Practice of David L. McGuffey, LLC

Your appointment with this office is: _____.
Our address is 400 N. Selvidge, Dalton, Georgia 30720.

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 (706) 428-0888 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 Dates:_____
SSN:	_____		
U. S. citizen?:	☐ Yes ☐ No		
Veteran?:	☐ Yes ☐ No Dates: _____		

Marriage Information:

Date and place of marriage:_____

(If your last marriage ended by divorce:)
Date and place of divorce:_____

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

2. Children

Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Email:		Email:	
Spouse:		Spouse:	
Children:		Children:	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Email:		Email:	
Spouse:		Spouse:	
Children:		Children:	
Name:		Name:	
Address:		Address:	
Phone:		Phone:	
Email:		Email:	
Spouse:		Spouse:	
Children:		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, who?:_____

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

3. 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:

	Your Mother	**Your Father**
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 #:

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.

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. Resources

Monthly Income

Do not list interest or dividend income.

Source	Amount
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: _____

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?: _____

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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: _____

(Use additional pages as necessary)

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: _____
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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.):

Personal Property (Item)	**Value**

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

OR

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

Company: _____ Premium Amt: $_____

Medicare Supplement ("Medigap")

Company: _____

Type (Plan A through J):_____ Premium Amt: $_____

Medicare Prescription Drug Plan

Company: _____ Premium Amt: $_____

Employer Retiree Health Plan

Company: _____ Premium Amt: $_____

Private Health Insurance

Company: _____ Premium Amt: $_____

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: _____

Would you like us to try to get you a quote on Long-term care Insurance? _____

6. 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
Total	

7. Money You Owe

Creditor's Name	Amount Owed
Total	

8. 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, (in Tennessee, 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**

9. Gifts and Transfers

Have you made any gifts or transfers, greater than $500.00, to any individuals or to a trust within the last 60 months? ☐ Yes ☐ No

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

To whom:		To whom:	
Date of gift:		Date of gift:	
Item:		Item:	
Value:		Value:	
To whom:		To whom:	
Date of gift:		Date of gift:	
Item:		Item:	
Value:		Value:	

10. 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. If there are any other documents you have questions about, please bring them as well.

Please provide the remaining information below only if the above documents are not in place or you want to make changes to these documents in 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.

Upon my death, I want to give
☐ Everything 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

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 #:

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:_____

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

_____

_____

_____

_____

_____

We cannot provide accurate advice without accurate information. The Elder Law Practice and its staff 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

_____
Printed Name

If you have any of the following documents, please provide copies:

- Last Will & Testament
- Trust (of any kind)
- Power of Attorney
- Health Care Advance Directive (of HC Power of Attorney or Living Will)

Revised: March 2009