



FRANKLIN & KYLE

ELDER LAW

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CONFIDENTIAL PLANNING INFORMATION

For use by Franklin & Kyle Elder Law, LLC (formerly Monica Franklin & Associates)

Appointment Date & time: _____ **Referred by:** _____
 May we contact the person who referred you and thank him/her? Yes No

Please fill out this packet completely, even if you are bringing documentation to the consult.
 These questions pertain to the person(s) for whom we are planning. We ask a lot of questions on this form because we need a lot of information in order to offer the best planning advice. Please call us if you have any questions.

1. INFORMATION ABOUT POTENTIAL CLIENT(S):

Name:	Name of Spouse/Partner:
SSN:	SSN:
Date of Birth:	Date of Birth:
Place of Birth:	Place of Birth:
Residence: <input type="checkbox"/> Home <input type="checkbox"/> Facility	Is this person living? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Facility, Name :	If no, date of death:
Date began living there:	Residence: <input type="checkbox"/> Home <input type="checkbox"/> Facility
Residence Address:	If Facility, Name :
City, State, Zip:	Date began living there:
County:	Residence Address:
Mailing Address:	City, State, Zip:
City, State, Zip:	County:
Phone:	Mailing Address:
Mobile:	City, State, Zip:
Email:	Phone:
U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Mobile:
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Email:
If Veteran, Dates of Service:	U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No
Branch of Military:	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name/Phone of Primary Contact:	If Veteran, Dates of Service:
	Branch of Military:

**Please add additional sheets if needed. Please do not write on the back of the pages.*

2. INFORMATION ON MARRIAGE:

Date and Place of Marriage: _____

Any previous marriages? Yes No Who: _____

If yes, Name of previous spouse(s): _____

How did this marriage end? divorce spouse died Date: _____

3. INFORMATION ABOUT CHILDREN (please list all)

If you are not a child but are completing this packet on someone's behalf, please list your information and relationship to the prospective client. *Please add additional sheets if needed.*

Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Email:	Email:
DOB:	DOB:
Spouse Name:	Spouse Name:
Children (indicate birthdates):	Children (indicate birthdates):
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Email:	Email:
DOB:	DOB:
Spouse Name:	Spouse Name:
Children (indicate birthdates):	Children (indicate birthdates):

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

Are any of your children or other family members receiving Supplemental Security Income, Social Security Disability; or, if not, do they have any major disabilities? Yes No If yes, who? _____

4. INFORMATION ABOUT YOUR HEALTH:

What medical or health problems do you currently have?

CLIENT	SPOUSE/PARTNER

What medical problems have you had in the past?

CLIENT	SPOUSE/PARTNER

Medications: Please list all of the medications you are currently taking and why.

CLIENT	SPOUSE/PARTNER

When were you last in the hospital & why?

CLIENT	SPOUSE/PARTNER

Physicians:

CLIENT	SPOUSE/PARTNER
Name:	Name:
Specialty:	Specialty:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Date of last visit:	Date of last visit:
Name:	Name:
Specialty:	Specialty:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Date of last visit:	Date of last visit:
Name:	Name:
Specialty:	Specialty:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Date of last visit:	Date of last visit:

5. INFORMATION ABOUT YOUR HEALTH INSURANCE:

CLIENT	SPOUSE/PARTNER
<i>PRIMARY INSURANCE</i>	<i>PRIMARY INSURANCE</i>
Provider:	Provider:
Policy #:	Policy #:
Monthly premium:	Monthly premium:
<i>SECONDARY INSURANCE/SUPPLEMENT</i>	<i>SECONDARY INSURANCE/SUPPLEMENT</i>
Provider:	Provider:
Policy #:	Policy #:
Monthly premium:	Monthly premium:
<i>PRESCRIPTION DRUG PLAN</i>	<i>PRESCRIPTION DRUG PLAN</i>
Provider:	Provider:
Policy #:	Policy #:
Monthly premium:	Monthly premium:

Do you have Long Term Care Insurance? Yes No

If yes, Policy Carrier Name:	Monthly Premium:
Daily Benefit:	Maximum Payout:

6. INFORMATION ABOUT FUNCTIONAL LIMITATIONS & 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.

Activities of Daily Living: Please mark the appropriate boxes.

CLIENT			SPOUSE/PARTNER				
	Need No Help	Need Some Help	Unable to do at all		Need No Help	Need Some Help	Unable to do at all
Bathing				Bathing			
Dressing				Dressing			
Transferring (bed to chair)				Transferring (bed to chair)			
Walking				Walking			
Feeding Self				Feeding Self			
Toileting				Toileting			
Grooming				Grooming			

Instrumental Activities of Daily Living: Please mark the appropriate boxes.

CLIENT			SPOUSE/PARTNER				
	Need No Help	Need Some Help	Unable to do at all		Need No Help	Need Some Help	Unable to do at all
Using the telephone				Using the telephone			
Getting out by car or transport				Getting out by car or transport			
Grocery Shopping				Grocery Shopping			
Preparing meals				Preparing meals			
Housework/ Handyman work				Housework/ Handyman work			
Laundry				Laundry			
Managing \$				Managing \$			
Taking medications				Taking medications			

Do you or your spouse or partner use any special equipment? Yes No

(I.e. cane, walker, wheelchair, scooter, transfer board, lift, hospital bed, oxygen, special mattress, etc.)

If yes, please list equipment and who uses it:

Does anyone provide assistance or caregiving? Yes No
 (I.e. assistance with activities of daily living, housekeeping, yard work, transportation, etc.)

If yes, please list their information:

Name:	Name:
Relationship:	Relationship:
Care/Assistance Provided:	Care/Assistance Provided:
How often:	How often:
Compensation:	Compensation:

7. INFORMATION ABOUT INCOME & ASSETS:

Monthly Income:

Even though you may bring a spreadsheet or statements, **PLEASE** complete our form.

SOURCE	CLIENT INCOME	SPOUSE/PARTNER INCOME	JOINT
Social Security			
Retirement Pension			
VA pension/benefit			
Wages			
IRA distribution			
Annuity payment			
Other			
Other			
TOTAL			

Personal Residence:

Address of property: _____

Names as they appear on the Deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax Appraised Value: _____

Mortgage Balance: _____ Mortgage Company: _____

Other Real Estate: (continued on next page)

Address of property: _____

Names as they appear on the Deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax Appraised Value: _____

Mortgage Balance: _____ Mortgage Company: _____

Other Real Estate: (continued)

Address of property: _____

Names as they appear on the Deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax Appraised Value: _____

Mortgage Balance: _____ Mortgage Company: _____

Address of property: _____

Names as they appear on the Deed: _____

Date Acquired: _____ Purchase Price: _____

Current Value: _____ Tax Appraised Value: _____

Mortgage Balance: _____ Mortgage Company: _____

**Please add additional sheets if needed. Please do not write on the back of the pages.*

Personal Property:

List large items of personal property that you own (cars, boats, RV's, farm equipment), or any valuable collections (antiques, coins, stamps, guns, etc.)

Item: _____ Value: _____

Item: _____ Value: _____

Item: _____ Value: _____

Item: _____ Value: _____

Item: _____ Value: _____

Item: _____ Value: _____

Life Insurance: (Including any policies through your employer)

Company Name: _____ Policy Owner: _____

Insured: _____ Beneficiary(s): _____

Death benefit: _____ Cash Surrender Value: _____

Loan against policy (if any): _____

Company Name: _____ Policy Owner: _____

Insured: _____ Beneficiary(s): _____

Death benefit: _____ Cash Surrender Value: _____

Loan against policy (if any): _____

Company Name: _____ Policy Owner: _____

Insured: _____ Beneficiary(s): _____

Death benefit: _____ Cash Surrender Value: _____

Loan against policy (if any): _____

Other Assets:

(bank accounts, CD's, annuities, stocks, Individual Retirement Accounts (IRA's), 401K's, other retirement, etc.)

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

Type of Asset: _____ Value: _____

Company Name: _____

Name(s) on the Account: _____

Beneficiaries: _____

TOTAL VALUE OF ASSETS ON THIS PAGE: _____

**Please add additional pages if needed. Please do not write on the back of the page. Thank you!*

Business and Digital Assets:

Do you or your spouse/partner have an ownership interest in a corporation (C-corp, LLC, S-corp) or partnership or other business? Yes No

If yes, explain:

Do you or your spouse/partner have an interest in any digital assets that are valuable (domain names, blogs, trademarks, royalties, etc.)? Yes No

If yes, explain:

8. INFORMATION ABOUT MONTHLY EXPENSES:

EXPENSE	MONTHLY COST
Property Tax	
Home maintenance and upkeep	
Homeowners insurance	
Utilities (gas, electric, water & sewer, security)	
Telephone	
Cable TV/Internet	
Auto operation (gas and maintenance)	
Auto insurance	
Groceries and other household	
Laundry and cleaning	
Clothing	
Hair cuts, personal grooming	
Newspapers and magazines	
Recreation, vacation, entertainment	
Checking account charges/bank fees	
Charitable contributions	
Life Insurance	
Health Insurance (such as Medicare supplement)	
Unreimbursed medical expense (such as for medications)	
Residential facility	
Private health care services	
Other: _____	
Other: _____	
Other: _____	
Other: _____	
Other: _____	
TOTAL MONTHLY EXPENSES:	

9. INFORMATION ABOUT DEBT:

Do you or your spouse/partner owe any amounts to creditors? (I.e. car loans, credit cards, mortgage, reverse loans, HELOC, outstanding medical bills) Yes No

If yes, please provide the information below for each debt:

Creditors Name:	Amount owed:
Creditors Name:	Amount owed:
Creditors Name:	Amount owed:
Creditors Name:	Amount owed:
Creditors Name:	Amount owed:

10. INFORMATION ABOUT GIFTS OR TRANSFERS:

Have you or your spouse/partner made any gifts or transfers over \$500.00 to any person or trust in the past 60 months? Yes No

If yes, please provide the information below for each gift or transfer:

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

11. INFORMATION ABOUT FUNERAL ARRANGEMENTS:

CLIENT	SPOUSE/PARTNER
Do you want to be <input type="checkbox"/> buried <input type="checkbox"/> cremated?	Do you want to be <input type="checkbox"/> buried <input type="checkbox"/> cremated?
Do you have prepaid funeral/burial?	Do you have prepaid funeral/burial?
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list info. below:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list info. below:
Funeral home:	Funeral home:
Phone:	Phone:
Do you own a cemetery plot or similar?	Do you own a cemetery plot or similar?
<input type="checkbox"/> Yes <input type="checkbox"/> No Value: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Value: _____
Location:	Location:
Do you wish to be an organ donor?	Do you wish to be an organ donor?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

12. ESTATE PLANNING:

Check any of the following documents that you have and please bring these into the meeting.

DOCUMENT	CLIENT		SPOUSE/PARTNER	
Durable Power of Attorney (POA Finances)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Advance Directive/Healthcare POA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Living Will	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Revocable Trust	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide the following information only if the above documents are not in place or you want to make changes to these documents in our planning process. (If you aren't sure what you want to do, you don't have to make the choices right now, we can discuss your choices at the meeting).

CLIENT	SPOUSE/PARTNER
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POA FINANCES: 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?

1. Name:	1. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:
2. Name:	2. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

POA HEALTH CARE: If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult about your care?

1. Name:	1. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:
2. Name:	2. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

WILL DETAILS: Who do you want to serve as your **executor**?

1. Name:	1. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

2. Name:	2. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

WILL DETAILS: If you want a trust set up for your children, grandchildren or anyone else, who do you want for the **trustee** of the trust?

1. Name:	1. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

2. Name:	2. Name:
Address:	Address:
Phone:	Phone:
Relationship:	Relationship:

WILL DETAILS: Briefly describe who you would like your estate/belongings to go to upon your death.

13. ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW?

14. QUESTIONS YOU WOULD LIKE ADDRESSED AT THE CONSULT?
