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 and 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 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: ☐ Home ☐ Facility	Residence: ☐ Home ☐ Facility
If Facility, Name:	If Facility, Name:
Date began living there:	Date began living there:
Residence Address:	Residence Address:
City, State, Zip:	City, State, Zip:
County:	County:
Mailing Address:	Mailing Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Mobile:	Mobile:
Email:	Email:
US Citizen: ☐ Yes ☐ No	US Citizen: ☐ Yes ☐ No
If Veteran, Dates of Service:	If Veteran, Dates of Service:
Branch of Military:	Branch of Military:
	Is this person living? ☐ Yes ☐ No If not, what is the date of death? _____________
Name/Phone of Primary Contact:	

*****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? ☐ Spouse died ☐ Divorce 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:
Date of Birth:	Date of Birth:
Spouse's Name:	Spouse's Name:
Children (indicate birthdates):	Children (indicate birthdates):
Name:	**Name:**
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Email:	Email:
Date of Birth:	Date of Birth:
Spouse's Name:	Spouse's 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 and 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**
Primary Insurance	***Primary Insurance***
Provider:	Provider:
Policy #:	Policy #:
Monthly Premium:	Monthly Premium:
Secondary Insurance	***Secondary Insurance***
Provider:	Provider:
Policy #:	Policy #:
Monthly Premium:	Monthly Premium:
Prescription Drug Plan	***Prescription Drug Plan***
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			
	Needs No Help	Needs Some Help	Unable to do at all		Needs No Help	Needs Some Help	Unable to do at all
Using the phone				Using the phone			
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			

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

CLIENT				SPOUSE/PARTNER			
	Needs No Help	Needs Some Help	Unable to do at all		Needs No Help	Needs Some Help	Unable to do at all
Using the phone				Using the phone			
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/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*	
Personal Property?	
List large items of personal property that you own (cars, boats, RVs, farm equipment) or any valuable collections (antiques, coins, stamps, guns, etc.)	
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, CDs, annuities, stocks, Individual Retirement Accounts, 401Ks, other retirement, etc.)	**Value:**
Type of Asset:	
Company Name:	
Name(s) on the Account:	
Beneficiaries:	
Type of Asset:	
Company Name:	
Name(s) on the Account:	
Beneficiaries:	
Type of Asset:	
Company Name:	
Name(s) on the Account:	
Beneficiaries:	
Type of Asset:	
Company Name:	
Name(s) on the Account:	
Beneficiaries:	
Type of Asset:	
Company Name:	
Name(s) on the Account:	
Beneficiaries:	
Type of Asset:	
Company Name:	
Name(s) on the Account:	
Beneficiaries:	
Type of Asset:	
Company Name:	
Name(s) on the Account:	
Beneficiaries:	
Type of Asset:	
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 ownership 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 and sewer, security)	
Telephone	
Cable TV/Internet	
Auto Operation (gas and maintenance)	
Auto Insurance	
Groceries and Other Household Items	
Laundry and Cleaning	
Clothing	
Hair Cuts and 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 Expenses (such as medication costs)	
Residential Facility	
Private Health Services	
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:

Creditor's Name:	Amount Owed:
Creditor's Name:	Amount Owed:
Creditor's Name:	Amount Owed:
Creditor's Name:	Amount Owed:
Creditor's 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 ☐ Buried ☐ Cremated?	Do you want to be ☐ Buried ☐ Cremated?
Do you have prepaid funeral/burial? ☐ Yes ☐ No If yes, list info below:	Do you have prepaid funeral/burial? ☐ Yes ☐ No If yes, list info below:
Funeral Home:	Funeral Home:
Phone:	Phone:
Do you have a cemetery plot or similar? ☐ Yes ☐ No Value:	Do you have a cemetery plot or similar? ☐ Yes ☐ No Value:
Location	Location
Do you wish to be an organ donor? ☐ Yes ☐ No ☐ Unsure	Do you wish to be an organ donor? ☐ Yes ☐ No ☐ Unsure

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)	☐ Yes ☐ No	☐ Yes ☐ No
Advance Directives/Healthcare POA	☐ Yes ☐ No	☐ Yes ☐ No
Will	☐ Yes ☐ No	☐ Yes ☐ No
Living Will	☐ Yes ☐ No	☐ Yes ☐ No
Revocable Trust	☐ Yes ☐ No	☐ Yes ☐ 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
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:
City/State:	City/State:
Phone:	Phone:
Relationship:	Relationship:
2. Name:	2. Name:
Address:	Address:
City/State:	City/State:
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:
City/State:	City/State:
Phone:	Phone:
Relationship:	Relationship:
2. Name:	2. Name:
Address:	Address:
City/State:	City/State:
Phone:	Phone:
Relationship:	Relationship:
Will Details: *Who do you want to serve as your executor?*	
1. Name:	1. Name:
Address:	Address:
City/State:	City/State:
Phone:	Phone:
Relationship:	Relationship:

2. Name:	2. Name:
Address:	Address:
City/State:	City/State:
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:
City/State:	City/State:
Phone:	Phone:
Relationship:	Relationship:
2. Name:	2. Name:
Address:	Address:
City/State:	City/State:
Phone:	Phone:
Relationship:	Relationship:
Will Details: *Briefly describe who you would like your estate/belongings to go to upon your death*	

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

14. WHAT QUESTIONS WOULD YOU LIKE ADDRESSSED AT THE CONSULT?