Date Completed: _____

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**** Note – we use this form for many purposes and not all information requested may apply to your situation. Please write "N/A" where appropriate. If you are completing this form for someone else as their attorney in fact, please note that at the top of this form.**

Client Information Form

Personal Data:

Name: _____ DOB: _____ SSN: _____

Address: _____

County: _____ Day Phone: _____ Eve. Phone: _____

E-Mail: _____ Employer: _____ Retirement Date: _____

Veteran: _____Yes _____No Service Branch: _____

Spouse/Partner: _____ DOB: _____

SSN: _____

Employer: _____ Retirement Date: _____

Veteran: _____Yes _____No Service Branch: _____

Do you and your spouse have a spiritual advisor? _____

Who referred you to our office: _____

****

Family Data:

Date of Marriage: _____ Place of Marriage: _____

Children of the Marriage:

First Name MI Last Name Age Spouse's Name Child's DOB

Address City State Zip Phone Number

First Name MI Last Name Age Spouse's Name Child's DOB

Address City State Zip Phone Number

First Name MI Last Name Age Spouse's Name Child's DOB

Address City State Zip Phone Number

(*Please list any additional children on the back of this page*)

Do you or your spouse have children from a previous marriage? _____

Do you or your spouse have any children who have died leaving children? _____

Do you have special financial or care giving responsibility for any family members (aging parents, disabled children or grandchildren, or other relatives)? _____

Does anyone to whom you may be leaving part of your estate require any help or protection in managing money or other property? _____

****

Medical & Health Data:

Name and Address of Personal Physician: _____

Is anyone in your Family disabled? _____

Is anyone at risk because of medical condition or family history for becoming seriously ill or disabled? _____

_____

Health Insurance:

	You	Spouse/Partner
Medicare:	_____	_____
Medicare Supplement:	_____	_____
Insurance from Employment:	_____	_____
Long Term Care Insurance:	_____	_____
Other:	_____	_____

Who knows best how you like to live and would help you if you were incapacitated?

_____

_____

****

Monthly Income:

	You	Spouse/Partner	Joint
Social Security:	_____	_____	
Employment:	_____	_____	
Pension from _____:	_____	_____	
Pension from _____:	_____	_____	
IRS's, Annuities, etc.:	_____	_____	
Rental Income:	_____	_____	_____
Business Interest:	_____	_____	_____
Interest & Dividends:	_____	_____	_____
Other _____:	_____	_____	_____
TOTALS:	_____	_____	_____

Which sources of income have a benefit for a surviving spouse? _____

_____

Do you or your spouse have an interest in any business? _____

_____

Real Estate:

Property Address	Value	Mortgage (Tax Basis)	How is it Titled? (Names as they appear on the Deed)

Is any of the above real estate income-producing? If so, explain estimated annual income amount and arrangement: _____

_____

(*Please list any additional real estate owned on the back of this page*)

Income Producing Assets:
(Bank Accounts, CD's, Brokerage Accounts, Stocks, Bonds, US Savings Bonds, etc.)

Description and Location of Property (List number of shares, due date, and rate of return if applicable)	Value	Account Number	How is it Titled (Names as they appear on the Instrument)

Liabilities:

	Description	Balance Due	Monthly Payment	Maturity Date
Mortgages				

Notes to Banks _____ _____ _____ _____

Notes to Others _____ _____ _____ _____

Loans on Insurance _____ _____ _____ _____

Other _____ _____ _____ _____

Other _____ _____ _____ _____

Life Insurance:

	Policy #1	Policy #2	Policy #3	Policy #4	Policy #5
Policy Owner					
Life Insured					
Company					
Face Value					
Cash Value					
Yearly Cost					
Policy Number					
Beneficiary					

Are the owners of any of the policies different from the person whose life is insured? ___

_____

Other Property with Designated Beneficiaries:

Do you have IRA's, Vest Pension Plans, Annuities, or other assets that would pass upon your death to a particular beneficiary that you have designated?

Description of Property	Value	Account Number

_____ _____ _____

_____ _____ _____

Personal Property:
(Automobiles, RV's, Boats, Antiques, Heirlooms, Jewelry, Special Collections, etc.)

Description of Property	Value	How is it Titled?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****

Legal Information:

	You		Your Spouse/Partner	
	Date Made	Location of Original	Date Made	Location of Original
Last Will & Testament	_____	_____	_____	_____
Power of Attorney	_____	_____	_____	_____
Living Will	_____	_____	_____	_____
Health Care Power of Attorney	_____	_____	_____	_____

Living Trust:

Location of Important Papers? _____
_____

Do you (or your spouse) have any financial obligations arising from dissolution of marriage or child support actions? _____

_____

Are you (or your spouse) the legally appointed guardian of another person? _____

_____

Have you (or your spouse) been appointed for anyone else under a power of attorney form? _____

_____

Are you (or your spouse) serving as the executor or administer of an estate? _____

_____

Have you (or your spouse) or will you (or your spouse) sign health care contracts for anyone? _____

_____

Are you (or your spouse) obligated on other contracts or documents? _____

_____

Are you (or your spouse) involved in a lawsuit? _____

_____

Have you (or your spouse) lived in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington State, or Wisconsin)? _____

_____

Have you ever filed or should you have filed a Federal Gift Tax Return (Form 790)?

_____Yes _____No

Are you a party to any pre-nuptial or post-nuptial agreement?

_____Yes _____No

Have you made any gifts/transfers in the past 5 years? Please explain. _____

_____

_____

Do you have other legal concerns that you wish to discuss? _____

_____

_____

Name and phone number of person completing this form: _____

_____

Medicaid specific information (if applicable):

Describe the physical/mental problems of the potential Medicaid recipient(s):_____

_____

_____

_____

Is the potential Medicaid recipient currently institutionalized? _____Yes _____No
If yes, where? _____

If the potential Medicaid recipient is currently residing in a long term facility, was he/she hospitalized prior to such admission to the LTC facility? _____Yes _____No
If yes, list the date and duration of the hospitalization: _____

Is the potential Medicaid recipient competent to sign legal documents in your opinion?

_____Yes _____No

Has the potential Medicaid recipient and/or his/her spouse made any gifts to any person other than his/her spouse from any trust within the five (5) years?

_____Yes _____No

If yes to the above questions regarding gifts, please provide the following information:

	Date of gift	Description of Gift	Estimated Value	Recipient
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____