

*To take the next step in your estate planning needs, please complete the questionnaire below and bring it with you to your consultation appointment.*

This questionnaire provides us with a snapshot picture of your situation.

Please check each box below that describes the purpose of your visit.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | To have my/our existing estate plan reviewed | |  | To learn more about estate planning |
|  | To protect my children’s/grandchildren’s inheritance from divorces and creditors | |  | To reduce or eliminate estate taxes |
|  | To protect my/our assets from lawsuits and future judgement creditors | |  | To reduce or eliminate capital gains taxes |
|  | To start a gift program to children, grandchildren, or others | |  | To reduce or eliminate the costs of probate |
|  | To protect my IRA or other retirement plans from excessive taxes | |  | I am not sure exactly what I need |
|  | Other: |  | | |

**ABOUT YOU AND** **YOUR SPOUSE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Your legal name | Name you want us to call you | | | U.S. Citizen?  Yes  No |
| Social Security Number  **-****-** | Your date of birth | | | Your Health? Good Fair  Poor |
| Spouse’s Legal Name | Name you want us to call spouse | | | U.S. Citizen? Yes  No |
| Spouse’s Social Security Number  **-****-** | Spouse’s Date of Birth | | | Spouse’s Health?  Good  Fair  Poor |
| Your full address, City, ST Zip | | | | Date of marriage |
| Email: | Spouse’s Email: | | | In which County of Georgia do you reside? |
| Home phone  **(****)** **-** | Business Phone  **(     )      -** | | | Name of Subdivision |
| For confirmations via text message, please list your phone carrier: | | |  | |
| **PLEASE NOTE:** *Texting is for scheduling purposes only. Legal questions* ***cannot*** *be answered via text message.* | | | | |
| Your current occupation. If retired, from what? | | Spouse’s current occupation. If retired, from what? | | |

**YOUR CHILDREN**, if any

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Legal name | Whose child is this?  Husband Wife Both | Date of Birth | If married, Spouse’s name | Does this child have children?  Yes  No |
| Legal name | Whose child is this?  Husband Wife Both | Date of Birth | If married, Spouse’s name | Does this child have children?  Yes  No |
| Legal name | Whose child is this?  Husband Wife Both | Date of Birth | If married, Spouse’s name | Does this child have children?  Yes  No |
| Legal name | Whose child is this?  Husband Wife Both | Date of Birth | If married, Spouse’s name | Does this child have children?  Yes  No |

**WHO REFERRED YOU TO US?**

|  |  |  |
| --- | --- | --- |
| Name | Firm | Phone  **(     )      -** |

**ARE/ WERE YOU OR YOUR SPOUSE A VETERAN? (Applicable only for VA Pension Applicants)**

|  |  |  |
| --- | --- | --- |
| Branch of Service: | Discharge Status? (Honorable/Dishonorable) | Do you have a copy of your DD214/Discharge papers? |

**YOUR ASSETS**

Please provide us with an estimate of the value of your estate by completing the following schedule. Use your **best estimate** of each asset’s value, assuming you could cash it in or sell it today at a fair price. Disregard what you paid for the asset or what it was worth when you inherited it.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ASSET | VALUE IN  YOUR NAME | VALUE IN  SPOUSE’S NAME | VALUE IN JOINT NAMES W/ SPOUSE | AMOUNT OF DEBT ON ASSET |
| Real Estate: Homestead |  |  |  |  |
| Real Estate: Investment |  |  |  |  |
| Money Owed to You |  |  |  |  |
| Business |  |  |  |  |
| Death Benefit of Life Insurance |  |  |  |  |
| Annuities |  |  |  |  |
| IRAs and other Retirement Plans |  |  |  |  |
| Brokerage Accounts/ Mutual Funds |  |  |  |  |
| Individually-held Stocks & Bonds |  |  |  |  |
| Checking, Savings, Money Market |  |  |  |  |
| Vehicles, Boats & Planes |  |  |  |  |
| Household Goods |  |  |  |  |
| Other Personal Effects |  |  |  |  |
| Other |  |  |  |  |
| **Totals** |  |  |  |  |

**YOUR ADVISORS** (In case we need to consult with them)

|  |  |  |  |
| --- | --- | --- | --- |
| Accountant |  | Firm | Phone (**)      -** |
| Financial Advisor |  | Firm | Phone (**)      -** |
| Financial Advisor |  | Firm | Phone (**)      -** |
| Life Insurance Agent |  | Firm | Phone (**)      -** |
| Attorney, if other than us |  | Firm | Phone (**)      -** |

**ARE YOU A VETERAN? (Applicable only for VA Pension Applicants)**

|  |  |  |
| --- | --- | --- |
| Branch of Service: | Discharge Status? (Honorable/Dishonorable) | Do you have a copy of your DD214/Discharge papers? |

**Any previous marriages? Veteran (how many?):       Spouse (how many?):**

Will you be able to provide or order marriage licenses for any/all marriages listed?

The veteran is (check all that apply)

|  |  |
| --- | --- |
| Officer or Enlisted | On Medal of Honor Roll |
| Receiving VA service connected disability pay? | Receiving military retirement pay $ |
| Formerly a POW (please give short description) |  |
|  | |

**Please check all that apply:**

**Veteran Spouse**

Housebound?

Disabled or incapacitated? Or declared incompetent?

Needs assistance performing basic daily activities?

In an Assisted Living Facility or Nursing home?

Under 65, declared disabled by Social Security Administration?

Applied for/Receiving Medicaid? Type:

Diagnosed with dementia/Alzheimers? Stage:  Early  Mid  Late

Has muscular degeneration? Extent:

|  |  |  |  |
| --- | --- | --- | --- |
| Has claimant been hospitalized in last 12 months? | | Yes  No ­ Dates: |  |
| Name and address of facility: |  | |

**Please list regular sources of monthly income and amounts:**

**Veteran Spouse**

|  |  |  |  |
| --- | --- | --- | --- |
| Social Security: | $ |  | $ |
| Pension: | $ |  | $ |
| Other: | $ |  | $ |

**Please list how much you are paying out of pocket for the following:**

**Veteran Spouse**

|  |  |  |  |
| --- | --- | --- | --- |
| In-Home Care Services: | $ |  | $ |
| Assisted Living Facility: | $ |  | $ |
| Health Insurance (NOT Medicare): | $ |  | $ |
| Long Term Care Premiums: | $ |  | $ |
| Doctor’s co-pays: | $ |  | $ |
| **Total unreimbursable expenses**: | $ |  | $ |

|  |  |  |
| --- | --- | --- |
| **ESTATE PLANNING BACKGROUND** | **You** | **Spouse** |
| In what year did you sign your most current Will? |  |  |
| Has your family/household changed since your last Will? |  |  |
| Do your children still require a guardian? |  |  |
| Do you have a financial Power of Attorney? |  |  |
| Who will manage your finances if you are unable? |  |  |
| Do you have an Advance Directive for Healthcare? |  |  |
| Have you named a Guardian for your children? |  |  |
| Who will make healthcare decisions for you, if you are unable? |  |  |
| Do you own your home or rent? (personal residence) |  |  |
| Do you own any investment property? |  |  |

**Please tell us the following information about each property that you own:**

|  |  |
| --- | --- |
| **What is the full address?** |  |
| **In what county is it located?** |  |
| **Name of owner(s):** |  |
| **Approximate date/year of purchase:** |  |

**PLEASE CONSIDER WHO YOU MIGHT WANT TO REPRESENT YOU FOR THE FOLLOWING:**

(If you could jot down a few possible names, Patti will discuss them with you at your appointment.)

***TRUSTEE: A person authorized to administer your Trust, as well as successors:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *You:* | 1. |  | 2. |  | 3. |  |
| *Spouse:* | 1. |  | 2. |  | 3. |  |

***PERSONAL REPRESENTATIVE (Formerly known as Executor): A person who would be authorized to administer your Will after your death - (formerly known as Executor)***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *You:* | 1. |  | 2. |  | 3. |  |
| *Spouse:* | 1. |  | 2. |  | 3. |  |

***AGENT UNDER FINANCIAL POWER OF ATTORNEY: A person authorized to make financial decisions on your behalf (WHILE YOU ARE ALIVE):***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *You:* | 1. |  | 2. |  | 3. |  |
| *Spouse:* | 1. |  | 2. |  | 3. |  |

***HIPAA AGENT: Person(s) authorized to receive healthcare information related to your care:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *You:* | 1. |  | 2. |  | 3. |  |
| *Spouse:* | 1. |  | 2. |  | 3. |  |

***HEALTHCARE AGENT: Person(s) authorized to make healthcare or end of life decisions for you if you are unable to do so:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *You:* | 1. |  | 2. |  | 3. |  |
| *Spouse:* | 1. |  | 2. |  | 3. |  |

***GUARDIAN: Person(s) who would care for your minor children upon your death or incapacity:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. |  | 2. |  | 3. |  |