

Estate Planning
Consult Information Sheet
(Married)

Date of Interview: _____
Location: _____ Boynton Ofc. Other: _____
Others Present: _____

CLIENT - GENERAL INFORMATION

1	Gender	Male	Female		
2	Salutation	Mr.	Mrs.	Ms	Dr.
3	Full Name				
4	Home Address				
5	City, State, Zip				
6	County				
7	Home Phone				
8	Cell Phone				
9	Work Phone				
10	Email				
11	Citizenship	U.S. Citizen & Resident	U.S. Resident	Other	

CLIENT - DETAILED INFO

12	Soc Sec Number	(Optional)		
13	DOB			
14	Age			
15	Client Veteran or Spouse of a Veteran	Yes	No	
16	How did you learn about us	Referred	Internet	Facebook
		GG law firm website	Print Ad	Direct Mail
17	If you were referred, who referred you			

CLIENT – MARITAL HISTORY

18	Client Marital Status	Date of Marriage _____
19	Children From CURRENT Marriage Yes _____ No _____	Child Full Name – Age - City/State. Note if Disabled: 1. _____ [] Disabled 2. _____ [] Disabled 3. _____ [] Disabled 4. _____ [] Disabled
20	Previous Marriage?	Yes _____ No _____ If Yes, Divorce Date: _____
21	Children From PREVIOUS Marriage Yes _____ No _____	Child Full Name – Age - City/State. Note if Disabled: 1. _____ [] Disabled 2. _____ [] Disabled 3. _____ [] Disabled 4. _____ [] Disabled

CLIENT - CURRENT ESTATE PLANNING DOCUMENTS

22	Client Current Will?	Yes _____ No _____ If yes, date: _____ STATE: _____ Comments: _____
23	Client Have any Trusts?	Yes _____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
24	Client Have Durable Power of Attorney?	Yes _____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
25	Client Have Health Care Directive?	Yes _____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
26	Client Have Living Will?	Yes _____ No _____ If Yes Date _____ STATE: _____ Withhold Nutrition: Yes: _____ No: _____

CLIENT PERSONAL OBJECTIVES

Personal Objectives in Wanting to Develop an Estate Plan <i>Rank how important each one is to you (1 = Low Priority 5 = High Priority)</i>			
	Name a spokesperson for me if I become Incapacitated (Avoid Guardianship).		Preserve eligibility for public benefits for a person I want to leave assets to (e.g., SSI and Medicaid).
	Direct how my assets are used and managed if I become Incapacitated.		Shift my assets in a manner that will provide opportunities to save nursing home costs if I need long-term care.
	Avoid Probate. Keep my affairs private upon my passing.		Preserve as much of my assets as I can for my family upon my passing. (e.g. minimize estate taxes)
	Protect assets left to spouse and family from lawsuits, judgements, bankruptcy, and divorce.		Provide detailed instructions for how I want to be cared for if I become incapable of communicating.

SPOUSE - GENERAL INFORMATION

1	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
2	Salutation	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms <input type="checkbox"/> Dr.
1	Full Name	
2	Home Address	
3	City, State, Zip	
4	County	
5	Home Phone	
6	Cell Phone	
7	Work Phone	
8	Email	
9	Citizenship	<input type="checkbox"/> U.S. Citizen & Resident <input type="checkbox"/> U.S. Resident <input type="checkbox"/> Other _____

SPOUSE - VITALS

12	Soc Sec Number	(Optional)
13	DOB	
14	Age	
15	Veteran or Spouse of a Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No

SPOUSE – MARITAL HISTORY

16	Previous Marriage	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Divorce Date: _____
17	Children PREVIOUS Marriage Yes _____ No _____	<p><u>Child Full Name – Age - City/State. Note if Disabled:</u></p> <p>1. _____ <input type="checkbox"/> Disabled</p> <p>2. _____ <input type="checkbox"/> Disabled</p> <p>3. _____ <input type="checkbox"/> Disabled</p> <p>4. _____ <input type="checkbox"/> Disabled</p>

SPOUSE - CURRENT ESTATE PLANNING DOCUMENTS

18	Client Current Will?	Yes _____ No _____ If yes, date: _____ STATE: _____ Comments: _____
19	Client Have any Trusts?	Yes _____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
20	Client Have Durable Power of Attorney?	Yes _____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
21	Client Have Health Care Directive?	Yes _____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
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	Protect assets left to spouse and family from lawsuits, predators, bankruptcy, and divorce.		Provide detailed instructions for how I want to be cared for if I become incapable of communicating.

LISTING OF ASSETS

(CONFIDENTIAL)

List all of the assets owned with current balance. It is important to be as accurate as possible. Include all bank checking, savings, and money market accounts, brokerage accounts, CD's, Bonds, Annuities, Life Insurance – Current Cash Surrender Value, Retirement Accounts current value.

GROSS MONTHLY INCOME

(CONFIDENTIAL)

List all sources of income. Be sure to list the **Gross Monthly Income** (Amount before any deductions).

Source	Client (Monthly Gross \$\$)	Spouse (Monthly Gross \$\$)	TOTAL
GROSS Social Security (Retirement)			
IRA (Traditional) – Distributions			
GROSS Pension Amount			
Interest			
Dividends			
Gross Wages			
Gross Total Income			

ADDITIONAL QUESTIONS	Client	Spouse
Where do you keep important papers (Wills, Insurance policies)		
Do you have safe deposit box (Location) Names who have access		
Expecting any inheritances (When how much from whom)		
Gift tax returns ever filed? Ever give gifts to any one person exceeding \$15,000?		

Cash Flow Analysis MONTHLY				
	Client Only	Spouse Only	Together	TOTAL
TOTAL MONTHLY GROSS INCOME (All Sources)				
SHELTER COSTS				
Mortgage Payment				
Property Taxes				
Home Insurance				
Condo/Assoc. Dues				
Electric				
Water/Sewer				
Cable TV				
Telephone				
Other: _____				
Other: _____				
Total Shelter Costs				
OTHER EXPENSES				
Food				
Entertainment				
Auto Payment				
Auto Insurance				
Gasoline				
Credit Card Pmts				
Other: _____				
Other: _____				
Other _____				
Total Other Expenses				
HEALTH CARE COSTS				
Medicare Part B Premium				
Medicare Part D Premium				
Health Insurance Supplement				
Care Managers/Nurse Services				
Co-Pays and Deductibles				
Other: _____				
Other: _____				
Total Health Care Costs				
Other: _____				
Other: _____				
GRAND TOTAL EXPENSES				
NET CASH FLOW				
Income taxes Paid - Last year				
Other Taxes: _____				
Other: _____				

TRANSFERS, GIFTS, OR SALES OF IN LAST 60 MONTHS
(Include any transfers from accounts held jointly with others)

(CONFIDENTIAL)

DEBTS

(CONFIDENTIAL)

COMMENTS/NOTES