ELDER LAW at
AHRENS DEANGELI
LAW GROUP

Confidential Planning Workbook

Planning for Married Couple
For Use by Ahrens DeAngeli Law Group LLP

Call us at (208) 387-0729 if you have any questions about completing this form. **Please bring copies of your most recent financial/bank statements, current estate planning documents and real property deeds to the meeting.**

1. Husband's Personal Information

Full Legal Name: _____
Name you want us to call you: _____
Date of Birth: _____/_____/_____ Age: _____
Are You A Veteran? ☐ **Yes** ☐ **No** Were you injured in service? ☐ **Yes** ☐ **No**

2. Wife's Personal Information

Full Legal Name: _____
Name you want us to call you: _____
Date of Birth: _____/_____/_____ Age: _____
Are You A Veteran? ☐ **Yes** ☐ **No** Were you injured in service? ☐ **Yes** ☐ **No**

Date of Marriage: _____ # of Years Married _____

3. Your Contact Information

Street Address: _____
City, State and Zip Code: _____
Home Phone: _____ Cell. Phone: _____
E-mail address: _____
Does anyone live with you besides your spouse? ☐ **Yes** ☐ **No**
If yes, who lives with you? _____

4. Income/Assets

Gross Monthly Income (*Do not list interest or dividend income.)*

Source	Husband's	Wife's
Social Security:		
Pension (From Previous Employer):		
IRA Distribution:		
VA:		
Other:		
Total:		

Assets: 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.

Source	Husband's	Wife's	Joint	Debt on Asset
Your Home				
2nd Home/Cabin/Land				
Checking:				
Savings:				
CDs:				
Investments (stocks/bonds, etc.):				
Annuities:				
IRA/401k:				
Business/LLCs etc.:				
Cash Value Life Ins:				
Prepaid Funeral Plan:				
Car 1:				
Car 2:				
Other Vehicles:				
Other _____:				
Other _____:				
Total:				

5. Real Estate

(Please bring a copy of the deed(s) on all real property you own to our meeting)

A. **Personal Residence**

Address of property: _____

Names as they appear on deed: _____

Current Value: _____ Tax-Appraised Value: _____

B. **If you own Other Real Estate/Land/Rental Properties, etc.**

Address of property: _____

Names as they appear on deed: _____

Current Value: _____ Tax-Appraised Value: _____

6. Monthly Expenses:

(Please note monthly expenses. If you have annual figures, divide by 12 months)

	Joint	Husband	Wife
HOUSING EXPENSES			
Home Care/Asst. Living/Nursing Home			
Mortgage/Rent			
2nd Mortgage			
Homeowner's Association Dues			
Property tax			
Homeowners insurance			
HEALTH INSURANCE EXPENSES			
Part D (Drug) Insurance Premium			
Health Insurance Premium			
Dental/Vision Premiums/Expenses			

7. Money You Owe (credit cards, outstanding medical bills, etc.)

Creditor's Name	Total Amount Owed
Total	

8. Money Owed to You (loans, promissory notes, mortgages, etc.)

Debtor's Name	Total Amount Owed
Total	

9. Gifts and Transfers

Have you made any gifts or transfers to any individuals within the last sixty (60) months? Gifts and transfers include money, property or goods given away or sold for less than fair market value and include charitable contributions. *(Use additional sheet if necessary)*

☐ **Yes** ☐ **No** **If yes, please furnish the indicated information for each gift or transfer:**

Name: _____ **Name:** _____
Month/Year: _____ **Month/Year:** _____
Item: _____ **Item:** _____
Value: _____ **Value:** _____

Name: _____ **Name:** _____
Month/Year: _____ **Month/Year:** _____
Item: _____ **Item:** _____
Value: _____ **Value:** _____

10. Insurance

(Please complete the following health insurance information as it applies to each of you.) Write the separate premium amount for each spouse.

Type of Insurance/Coverage	Husband	Wife
Traditional Medicare (physician and hospital – Part A/B)?		
Medicare Supplement? Company Name:		
Medicare Advantage/Replacement Plan? Company Name:		

Medicare Prescription (Part D)? Company Name:		
Employer Retiree Health Plan? Company Name:		
Type of Insurance/Coverage	**Husband**	**Wife**
Private Health Insurance? Company Name:		
Long Term Care Insurance (LTC) Contracts? Company Name: *Please bring copies of any LTC Contract Policies.*		
Annuity Contracts? Company Name: *Please bring copies of any Annuity Policies.*		
Other Type (cancer, accidental, hospital supp.)? Company Name:		

11. Information About Your Health

HUSBAND

A. **Do you have any health problems associated with long term care?**

_____

_____

B. **Name of your personal physician(s):**

Name: _____

Medical specialty: _____ Telephone #: _____

Address: _____

Name: _____

Medical specialty: _____ Telephone #: _____

Address: _____

WIFE

A. **Do you have any health problems associated with long term care?**

_____

_____

B. **Name of your personal physician(s):**

Name: _____

Medical specialty: _____ Telephone #: _____

Address: _____

Name: _____

Medical specialty: _____ Telephone #: _____

Address: _____

12. Functional Limitations and Support

HUSBAND

Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			
Taking Medications			

Are you getting assistance with the above activities? ☐ **Yes** ☐ **No**

WIFE

Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to Do At All**
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			
Taking Medications			

Are you getting assistance with the above activities? ☐ **Yes** ☐ **No**

13. Your Children

Child #1 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Child #2 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Child #3 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____ E-mail address: _____

Child #4 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____E-mail address: _____

Child #5 √ if deceased ☐

Full Legal Name: _____ Date of Birth: _____

Whose Child Is This? ☐ Husband's Child ☐ Wife's Child ☐ Both Spouses

Address: _____

Phone #: _____E-mail address: _____

Are any of your children or grandchildren disabled? ☐ Yes ☐ No

If yes, please list their names:_____

14. Estate Distribution Wishes

Do you have any of the following documents?	**Husband**		**Wife**	
Financial Power of Attorney	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Health Care Power of Attorney	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Living Will	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Last Will and Testament	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**
Revocable Living Trust	☐ **Yes**	☐ **No**	☐ **Yes**	☐ **No**

HUSBAND

Upon my death, I want to give
☐ Everything to my spouse, if my spouse survives me, otherwise to my children in equal shares
OR

☐ I want to make bequests different from those above. If you check this box, please explain in writing your estate distribution wishes here:

WIFE

Upon my death, I want to give
☐ Everything to my spouse, if my spouse survives me, otherwise to my children in equal shares
OR
☐ I want to make bequests different from those above. If you check this box, please explain in writing your estate distribution wishes here:

15. Administration of Financial Matters:

If you needed assistance with making financial decisions, who would you want to make financial decisions for you? (List in order of priority).

Husband

A. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

B. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

C. **Name (First M. Last):** _____
Address: _____

Relationship:_____ **Telephone #:**_____

Wife

A. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

B. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

C. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

16. Health Care Decision Making

If you were in the hospital and unable to make decisions for yourself, who would you want to make medical decisions for you? (List in order of priority)

Husband

A. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

B. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

C. **Name (First M. Last):** _____
Address:_____
Relationship:_____ **Telephone #:**_____

Wife

A. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

B. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

C. **Name (First M. Last):** _____
Address: _____
Relationship: _____ **Telephone #:** _____

17. Advisors

	Name	Firm	Phone #
Accountant/Tax Advisor			
Financial Advisor			
Insurance Agent			

We contact our clients' professional advisors and let them know that we are working with you. We will assume that is ok with you unless you tell us otherwise.

18. Legal Proceedings

Are you a party to any court proceeding? ☐ **Yes** ☐ **No**
If yes, please describe: _____
_____
_____

19. Anything else you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

The above information is true and correct to the best of my knowledge and belief.

_____

Your signature, or the signature of your attorney-in-fact