

# Life Care Planning Information for Couple for Use by Monica Franklin, CELA

Your appointment with this office is: \_\_\_\_\_.

Our Knoxville address is 4931 Homberg Drive, Knoxville, Tennessee 37919. Directions are enclosed.

**These questions pertain to the persons, Husband and Wife, for whom we are planning.**

We ask a lot of questions on this form because we need a lot of information about you for our planning for you. Do your best, but don't worry if some of the information you need to complete this form is not available to you.

Please call us at (865) 588-3700 if you have any questions or concerns about completing this form.

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

How did you find our phone number?  Yellow Pages  Friend  Relative  Seminar

Advertisement in the \_\_\_\_\_.  Other: \_\_\_\_\_

**1. Personal Information related to elder client. If you are a child, and we are meeting to discuss your parents, write your parents' info on this page. Your info should be written on the next page.**

Client's  
name

\_\_\_\_\_

Client's  
Spouse:

\_\_\_\_\_

Address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Place of birth: \_\_\_\_\_

Phone: \_\_\_\_\_

SSN: \_\_\_\_\_

Email: \_\_\_\_\_

U. S. citizen?:  Yes  No

County: \_\_\_\_\_

Veteran?:  Yes  No

Date of birth: \_\_\_\_\_

Address:  Same as Spouse

Place of birth: \_\_\_\_\_

Different:

SSN: \_\_\_\_\_

U. S. citizen?:  Yes  No

Veteran?:  Yes  No

Phone: \_\_\_\_\_

## Marriage Information

Date and place of marriage: \_\_\_\_\_

## Contact Information

If not you, who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?: Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**2. Children**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Children: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any dependents (that is, someone who depends on you, in whole or in part, for their support)?  Yes  No  
If yes, who?: \_\_\_\_\_

Are any of your children receiving Supplement Security Income, Social Security Disability; or, if not, has any major disabilities?  Yes  No  
If yes, who?: \_\_\_\_\_

**3. Information About Your Health**

**Husband:**

- 1. What medical or health problems do you currently have?
  
- 2. What medical problems have you had in the past?
  
- 3. Please list all of the medications you are currently taking:

Medication	Why Are You Taking This Drug?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- 4. Does your family have a history of health problems (for example, heart disease, cancer, or Alzheimer's disease)? Describe:

Tell us about your parents:

	Your Mother	Your Father
Age at Death:		
Cause of Death:		

- 5. Name of your personal physician(s):

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State:

\_\_\_\_\_

Medical specialty:

\_\_\_\_\_

Telephone #:

\_\_\_\_\_

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State:

\_\_\_\_\_

Medical specialty:

\_\_\_\_\_

Telephone #:

\_\_\_\_\_

**Wife:**

1. What medical or health problems do you currently have?

2. What medical problems have you had in the past?

3. Please list all of the medications you are currently taking:

Medication	Why Are You Taking This Drug?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Does your family have a history of health problems (for example, heart disease, cancer, or Alzheimer's disease)? Describe:

Tell us about your parents:

	Your Mother	Your Father
Age at Death:		
Cause of Death:		

5. Name of your personal physician(s):

Name:

Address:

City/State:

Medical specialty:

Telephone #:

Name:

Address:

City/State:

Medical specialty:

Telephone #:

#### 4. Functional Limitations and 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.

Why do we want this information? Measurement of the activities of daily living is critical because the more assistance people need with their daily activities, the more likely are they to be admitted to a nursing home or other living arrangement; to use paid home care; to use hospitals and doctors; and to die sooner rather than later.

Place an X in the box that most applies for each activity.

**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			

Instrumental Activities of Daily Living			
Activity	Need No Help	Need Some Help	Unable to Do At All
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

	Place Where You Live	Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Nursing home	

List the names of all persons who provide assistance or caregiving for you:

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**Wife:**

<b>Activities of Daily Living</b>			
<b>Activity</b>	<b>Need No Help</b>	<b>Need Some Help</b>	<b>Unable to Do At All</b>
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			

<b>Instrumental Activities of Daily Living</b>			
<b>Activity</b>	<b>Need No Help</b>	<b>Need Some Help</b>	<b>Unable to Do At All</b>
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

	<b>Place Where You Live</b>	<b>Since When?</b>
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Nursing home	

List the names of all persons who provide assistance or caregiving for you:

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**5. Resources**

**Monthly Income**

Do not list interest or dividend income.

Source	Husband	Wife	Joint
Social Security:			
Pension:			
Other:			
<b>Total:</b>			

**A. Personal Residence**

Address of property: \_\_\_\_\_

Names as they appear on deed: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Purchase Price: \_\_\_\_\_

Current Value: \_\_\_\_\_ Tax-Appraised Value: \_\_\_\_\_

Mortgage Company: \_\_\_\_\_

Mortgage Balance: \_\_\_\_\_

**B. Other Real Estate**

Address of property: \_\_\_\_\_

Names as they appear on deed: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Purchase Price: \_\_\_\_\_

Current Value: \_\_\_\_\_ Tax-Appraised Value: \_\_\_\_\_

Mortgage Company: \_\_\_\_\_

Mortgage Balance: \_\_\_\_\_

Address of property: \_\_\_\_\_

Names as they appear on deed: \_\_\_\_\_

Date Acquired: \_\_\_\_\_ Purchase Price: \_\_\_\_\_

Current Value: \_\_\_\_\_ Tax-Appraised Value: \_\_\_\_\_

Mortgage Company: \_\_\_\_\_

Mortgage Balance: \_\_\_\_\_

**Other Assets**

These are your bank accounts, CDs, annuities, stocks, retirement plans, and the like.

**Type of Asset:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled?: \_\_\_\_\_

**Type of Asset:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled?: \_\_\_\_\_

**Type of Asset:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled?: \_\_\_\_\_

**Type of Asset:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled?: \_\_\_\_\_

**Type of Asset:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled?: \_\_\_\_\_

**Type of Asset:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled?: \_\_\_\_\_

**Type of Asset:** \_\_\_\_\_

Name of Company: \_\_\_\_\_

Value: \_\_\_\_\_

How is it titled?: \_\_\_\_\_

**Total Value of Assets on this Page:** \_\_\_\_\_

Do you have a safe deposit box?  Yes  No

If yes, list name of bank, branch and box number.

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**List all life insurance.**

**Company Name:**

Owner: \_\_\_\_\_

Insured: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Death Benefit (face value): \_\_\_\_\_

Cash surrender value: \_\_\_\_\_

Loan against policy (if any): \_\_\_\_\_

**Company Name:**

Owner: \_\_\_\_\_

Insured: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Death Benefit (face value): \_\_\_\_\_

Cash surrender value: \_\_\_\_\_

Loan against policy (if any): \_\_\_\_\_

**Company Name:**

Owner: \_\_\_\_\_

Insured: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Death Benefit (face value): \_\_\_\_\_

Cash surrender value: \_\_\_\_\_

Loan against policy (if any): \_\_\_\_\_

**Personal Property.**

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.) or any valuable collections (antiques, coins and stamps, guns, etc.):

Personal Property (Item)	Value

**Other Insurance**

Please complete the following health insurance information as it applies to both of you:

**Husband:** Medicare: If you are not satisfied with your health insurance, please describe why on the back of this page.

Medicare

Traditional Medicare Fee-for-Service?       Yes  No

OR

Medicare HMO, PSO, PPO, Private Plan?       Yes  No

Company: \_\_\_\_\_

Medicare Supplement ("Medigap")

Company: \_\_\_\_\_

Type (Plan A through J): \_\_\_\_\_

Medicare Prescription Drug Plan

Company: \_\_\_\_\_

Employer Retiree Health Plan

Company: \_\_\_\_\_

Private Health Insurance

Company: \_\_\_\_\_

Long Term Care Insurance

Company: \_\_\_\_\_

Daily Benefit Amount: \_\_\_\_\_

Length of Coverage: \_\_\_\_\_

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)

Company: \_\_\_\_\_

Type: \_\_\_\_\_

Company: \_\_\_\_\_

Type: \_\_\_\_\_

Company: \_\_\_\_\_

Type: \_\_\_\_\_

**Wife:**

Medicare: If you are not satisfied with your health insurance, please describe why on the back of this page.

Traditional Medicare Fee-for-Service?       Yes  No

OR

Medicare HMO, PSO, PPO, Private Plan?       Yes  No

Company: \_\_\_\_\_

Medicare Supplement ("Medigap")

Company: \_\_\_\_\_

Type (Plan A through J): \_\_\_\_\_

Medicare Prescription Drug Plan

Company: \_\_\_\_\_

Employer Retiree Health Plan

Company: \_\_\_\_\_

Private Health Insurance

Company: \_\_\_\_\_

Long Term Care Insurance

Company: \_\_\_\_\_

Daily Benefit Amount: \_\_\_\_\_

Length of Coverage: \_\_\_\_\_

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)

Company: \_\_\_\_\_

Type: \_\_\_\_\_

Company: \_\_\_\_\_

Type: \_\_\_\_\_

**6. Monthly Expenses**

Item	Amount
Property tax	_____
Home maintenance and upkeep	_____
Homeowners insurance	_____
Utilities (gas, electric, water & sewer, security)	_____
Residential facility	_____
Private health care services	_____
Telephone	_____
Cable television	_____
Auto operation (gas and maintenance)	_____
Auto insurance	_____
Clothing	_____
Groceries and other household	_____
Hair cuts, personal grooming	_____
Laundry and cleaning	_____
Checking account charges/bank fees	_____
Newspapers and magazines	_____
Recreation, vacation, entertainment	_____
Health insurance (such as Medicare supplement)	_____
Unreimbursed medical expense (such as for drugs)	_____
Life insurance	_____
Charitable contributions	_____
Other: _____	_____
Other: _____	_____
<b>Total Monthly Expenses:</b>	_____

Anticipated maintenance needs to homestead (examples: roof, windows, painting, foundation repair, driveway, etc.)

Item	Cost
_____	_____
_____	_____
_____	_____
<b>Total</b>	_____

**7. Money You Owe**

Creditor's Name

Amount Owed

_____	_____
_____	_____
<b>Total</b>	_____

**8. Public Benefits and Community Services**

In addition to Social Security and Medicare, are you receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, TennCare, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group services, property tax relief, home weatherization, and drug company discount card programs.

Yes     No

If yes, please list them below:

<b>Provider</b>	<b>Form of assistance</b>
_____	_____
_____	_____

**9. Gifts and Transfers**

Have you made any gifts or transfers, greater than \$500.00, to any individuals or to a trust within the last 60 months?  Yes  No

If yes, please furnish the indicated information for each gift or transfer:

To whom: _____	To whom: _____
Date of gift: _____	Date of gift: _____
Item: _____	Item: _____
Value: _____	Value: _____
To whom: _____	To whom: _____
Date of gift: _____	Date of gift: _____
Item: _____	Item: _____
Value: _____	Value: _____

**10. Estate Planning**

<b>Do you have any of the following documents?</b>	<b>Husband</b>	<b>Wife</b>
Durable Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Place an X in the box that applies. Please bring the existing documents with you to our meeting.

**Please provide the remaining information below only if the above documents are not in place or you want to make changes to these documents in our planning process.**

There is a section to be completed for each of you (Husband and Wife).

**Note:** Please read all of the choices before selecting one. (If you aren't sure what you want to do, you don't have to make any choices right now.) We will discuss your choices at our meeting.

**Husband:**

<b>Upon my death, I want to give</b>
<input type="checkbox"/> Everything to my wife, if she survives me, otherwise to my children in equal shares <b>OR</b>
<u>Alternative #1</u>
<input type="checkbox"/> Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached age _____
<u>Alternative #2</u>
<input type="checkbox"/> Everything to my children and to my deceased spouse's children in equal shares.
<u>Alternative #3</u>
<input type="checkbox"/> I want to make bequests different from those above.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

Whom do you want to serve as your executor? Please give name and full addresses for a first choice, and for an alternate second choice.

1. Name:

---

Address:

---

---

City/State:

---

Relationship:

---

Telephone #:

---

2. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

If you want a trust set up for your children or grandchildren or anyone else, please give name and full addresses for a first choice trustee, and for an alternate second choice.

1. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

2. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

### ***Decision Making***

#### *Health Care*

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? (List in order of priority)

1. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

2. Name:

---

Address:

---

---

City/State: \_\_\_\_\_

---

Relationship: \_\_\_\_\_

---

Telephone #: \_\_\_\_\_

---

Do you want to be an organ donor?  Yes  No  Don't know

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference?  Yes  No

If yes, what religion are you?: \_\_\_\_\_

Do you want to be an organ donor?  Yes  No  Don't know

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference?  Yes  No

If yes, what religion are you?: \_\_\_\_\_

Do you (husband) want to be buried or cremated?

**Husband:** Buried  Cremated

Do you (husband) have a prepaid funeral or burial?  Yes  No

If yes, describe the arrangements:

Husband: \_\_\_\_\_

Wife: \_\_\_\_\_

*Legal and Financial*

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? (List in order of priority)

1. Name:

---

Address: \_\_\_\_\_

---

City/State: \_\_\_\_\_

---

Relationship: \_\_\_\_\_

---

Telephone #: \_\_\_\_\_

---

2. Name:

---

Address: \_\_\_\_\_

---

City/State: \_\_\_\_\_

---

Relationship: \_\_\_\_\_

---

Telephone #: \_\_\_\_\_

---

Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?:

- Yes     No     Don't know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

- No restrictions, I trust my attorney-in-fact to make the right decision.

My restrictions are: \_\_\_\_\_

**Wife:**

<b>Upon my death, I want to give</b>
<input type="checkbox"/> Everything to my husband, if he survives me, otherwise to my children in equal shares
<b>OR</b>
<u>Alternative #1</u>
<input type="checkbox"/> Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached age _____
<u>Alternative #2</u>
<input type="checkbox"/> Everything to my children and to my deceased spouse's children in equal shares.
<u>Alternative #3</u>
<input type="checkbox"/> I want to make bequests different from those above.

Do you want to leave any specific money or property to any individual, or to a charity?

Beneficiary	Item/Amount

Whom do you want to serve as your executor? Please give name and full addresses for a first choice, and for an alternate second choice.

1. Name:

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone #: \_\_\_\_\_

2. Name:

Address: \_\_\_\_\_

City/State: \_\_\_\_\_

Relationship: \_\_\_\_\_

Telephone #: \_\_\_\_\_

If you want a trust set up for your children or grandchildren or anyone else, please give name and full addresses for a first choice trustee, and for an alternate second choice.

1. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

2. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

### ***Decision Making***

#### *Health Care*

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)? (List in order of priority)

1. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

2. Name:

---

Address:

---

City/State:

---

Relationship:

---

Telephone #:

---

Do you want to be an organ donor?  Yes  No  Don't know

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference?  Yes  No

If yes, what religion are you?: \_\_\_\_\_

Do you (wife) want to be buried or cremated?

**Wife:**      Buried          Cremated   

Do you (wife) have a prepaid funeral or burial?     Yes     No

If yes, describe the arrangements:

Wife: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

---

*Legal and Financial*

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? (List in order of priority)

1. Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State:

\_\_\_\_\_

Relationship:

\_\_\_\_\_

Telephone #:

2. Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City/State:

\_\_\_\_\_

Relationship:

\_\_\_\_\_

Telephone #:

Do you want these persons (your attorneys-in-fact) to be able to make gifts of your property, if they believed that was necessary for tax reasons or to protect your assets?:

Yes     No     Don't know

If YES, what restrictions, if any, would you place on their authority to make gifts of your property (such as to family members only, certain charities, etc.)?

No restrictions, I trust my attorney-in-fact to make the right decision.

My restrictions are: \_\_\_\_\_ Revised: October 3, 2008