

Life Care Planning Information -Individual 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 or on our website.

These questions pertain to the person (“you”) 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: _____

Date of death: _____

Email: _____

Place of death: _____

County: _____

SSN: _____

Date of birth: _____

U. S. citizen?: Yes No

Place of birth: _____

Veteran?: Yes No

SSN: _____

U. S. citizen?: Yes No

Veteran?: Yes No

Marriage Information:

Date and place of marriage: _____

(If your last marriage ended by divorce:)

Date and place of divorce: _____

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

2. Children

Name: _____
Address: _____

Phone: _____
Email: _____
Date of Birth: _____
Date of Death: _____
Spouse: _____
Children and date of birth: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Date of Birth: _____
Date of Death: _____
Spouse: _____
Children and date of birth: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Date of Birth: _____
Date of Death: _____
Spouse: _____
Children and date of birth: _____

Name: _____
Address: _____

Phone: _____
Email: _____
Date of Birth: _____
Date of Death: _____
Spouse: _____
Children and date of birth: _____

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

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.

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:

5. Resources

Monthly Income

Do not list interest or dividend income.

Source	Amount
Social Security:	
Pension:	
Other:	
Total:	

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?: _____

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: _____

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): _____

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.):

Personal Property (Item)	Value

Other Insurance

Please complete the following health insurance information as it applies:

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: _____

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: _____	_____
	Total Monthly Expenses:	_____

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

Item	Cost
_____	_____
_____	_____
_____	_____
_____	_____
Total	_____

7. Money You Owe

Creditor's Name	Amount Owed
_____	_____
_____	_____
Total	_____

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:

Provider	Form of assistance
_____	_____
_____	_____
_____	_____
_____	_____

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: _____
Date of gift: _____
Item: _____
Value: _____

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

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

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

10. Estate Planning

Do you have any of the following documents?	Yes	No
Durable Power of Attorney		
Health Care Power of Attorney		
Living Will		
Will		
Revocable Living Trust		
Deeds (Warranty or Quit Claim deeds)		

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.

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.

Upon my death, I want to give
<input type="checkbox"/> Everything to my children in equal shares OR
<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 buried or cremated? Buried Cremated

Do you have a prepaid funeral or burial? Yes No

If yes, describe the arrangements: _____

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: _____