



1255 Lynnfield Road, Suite 117

Memphis, TN 38119-5161

901.820.0810

901.761.3813

A. SENIOR'S PERSONAL DATA

Full Name _____.

Home Address _____.

City: _____ State: _____ Zip: _____

May we correspond with you by e-mail? Yes No

If so, e-mail address: _____

Where is Senior currently residing (if different)? _____

Telephone: _____

Age & Birth Date _____

U.S. Citizen? Yes No

Veteran? Yes No

Existing Planning Documents:

1. Does Senior have a Durable Power of Attorney? Yes No

Health Care Power of Attorney? Yes No

2. Does Senior have a Will, Living Trust or similar document? Yes No

Is the Elder still able to execute legal documents? Yes No

PLEASE BRING COPIES OF EXISTING DOCUMENTS TO OUR FIRST MEETING.

CLIENT/REPRESENTATIVE:

Note: If Senior is unable to act as the client or has asked another to represent him or her in meeting with attorney, please provide the following information.

Client or Representative(s): _____

Relationship to Senior: _____

Address: _____

Contact Telephone Number(s): _____

May we correspond with you by e-mail? Yes No

If so, e-mail address: _____

B. MEDICAL DATA

1. HEALTH

General Health of Senior _____

Diagnosis _____

Prognosis _____

Course of Treatment _____

If Senior has entered a nursing home, please state the name of the nursing home and the date first entered on a continuous basis: _____

Date: _____

2. PHYSICIAN

Name of Primary Physician _____

Address _____

City: _____ State: _____ Zip: _____

3. HEALTH INSURANCE

Does Senior have private health insurance or Medicare Supplemental Insurance? Yes No

Insurance Carrier: _____

Cost per month? _____

Long Term Care Insurance? Yes No

C. APPROXIMATE MONTHLY COST OF CARE

\$ _____ Monthly Nursing Home/Assisted Living Cost

\$ _____ Monthly Prescription Cost

\$ _____ Monthly Supplies, Misc. Expenses

\$ _____ Monthly Home Mortgage, Taxes, Insurance

\$ _____ Other Costs _____

TOTAL MONTHLY COST: \$ _____

The nursing home is paid up through (month/year). _____

D. MONTHLY INCOME

Monthly Income

Social Security Benefits \$ _____ Is this after Part B deduction? _____

Retirement/Pension Benefits (Gross) \$ _____

VA Pension/Disability Benefit \$ _____ Aid & Attendance? Yes No

Annuity Income \$ _____

Rental, Interest and Other Income \$ _____

TOTAL MONTHLY INCOME \$ _____

If there is a pension, if possible, please list the *gross pension amount* (do not deduct any monies taken out for federal income taxes, health insurance, or any other reason).

E. ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space. You may add schedules if necessary for multiple accounts and CD's.

| ASSETS (explanation if necessary) | SOLE OWNERSHIP PROPERTY | JOINTLY OWNED PROPERTY (With Whom? Indicate Below.) | Debt | (For Office Use Only) COUNTABLE VALUE |
|---|-------------------------|---|------|--|
| RESIDENCE (Current ASSESSED VALUE) | | | | |
| AUTOMOBILE (second auto countable) | | | | |
| CHECKING ACCOUNT | | | | |
| SAVINGS ACCOUNT | | | | |
| MONEY MARKET ACCOUNT | | | | |
| CERTIFICATES OF DEPOSIT | | | | |
| IRA'S | | | | |
| MUTUAL FUNDS | | | | |
| STOCKS & BONDS | | | | |
| ANNUITIES | | | | |
| OTHER REAL ESTATE | | | | |
| CASH VALUE - LIFE INSURANCE (Total from Schedule G) | | | | |
| PREPAID FUNERAL/BURIAL PLOT | | | | |
| OTHER | | | | |
| | | | | |
| TOTALS | | | | |

Does Senior own any real estate other than personal residence?

(1) Type: _____

Location: _____

Current Value: _____

What did you pay for this property including any improvements? (Attach additional information if necessary)

F. GIFTS

Please list gifts made in excess of \$13,000 in any one year to an individual or group of individuals, within the past 5 years. (attach list, if necessary):

Recipient _____ Date _____ Amount \$ _____

Recipient _____ Date _____ Amount \$ _____

Recipient _____ Date _____ Amount \$ _____

Recipient _____ Date _____ Amount \$ _____

Have you ever filed a Federal Gift Tax Return? Yes No

If so, please state details _____

G. LIFE INSURANCE

If any insurance is from a Term or Group Policy, check Term in box. If it is Burial Insurance, check in box.

| Insurance Company | Indicate Type | Values* | Who is the: | Owner |
|-------------------|---------------|---------|-------------|-------|
| | Term [] | Face: | Insured: | |
| | | Cash: | Benefic.: | |
| | Term [] | Face: | Insured: | |
| | | Cash: | Benefic.: | |
| | Term [] | Face: | Insured: | |
| | Burial [] | Cash: | Benefic.: | |
| | Term [] | Face: | Insured: | |
| | Burial [] | Cash: | Benefic.: | |

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, check the annual statement from the company or call the insurance company directly.

* Also show the total Cash Value of all of the life insurance in the Life Insurance line in Section E.

H. CHILDREN and other family members
(If applicable, use back to continue, if necessary.)

1. _____ Telephone: _____
Name
_____ Age: _____
Street Address
_____ Married ? _____ Divorced ? _____
City, State, Zip
Children? _____

2. _____ Telephone: _____
Name
_____ Age: _____
Street Address
_____ Married ? _____ Divorced ? _____
City, State, Zip
Children? _____

3. _____ Telephone: _____
Name
_____ Age: _____
Street Address
_____ Married ? _____ Divorced ? _____
City, State, Zip
Children? _____

4. _____ Telephone: _____
Name
_____ Age: _____
Street Address
_____ Married ? _____ Divorced ? _____
City, State, Zip
Children? _____

Are any of the children blind or disabled? Yes No

Have all of the children completed their education? Yes No

Are any children receiving SSI or other Government entitlement payments? Yes No

Do any of the family members have any financial or health problems? Yes No

If so, please explain in conference. _____

Do any of the children or siblings live with you in Senior's home? Yes No

If yes, name of child or sibling: _____

I. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes No

If yes, please explain _____

J. REFERRAL

Who referred you to this office? _____

Name _____

Address _____

City _____ State _____ Zip _____

K. CERTIFICATION

The undersigned hereby represents that the information contained in this form is accurate and complete and that the undersigned understands that this law firm and its attorneys will rely on this information. I also understand that erroneous information may lead to recommendations that may not be appropriate.

Client or Client Representative