Kile Law Firm, P.C.
8727 E. Via de Commercio
Scottsdale, AZ 85258
Phone: 480-348-1590
Fax: 1-866-404-5085
Email: Info@kilelawfirm.com

We look forward to working with you on your estate plan. Please be sure to bring this document with you or email it to us before your meeting. We anticipate you will have questions and will not fill in all of the blanks—that is fine! We will review it together at your initial consultation.

GOALS

Avoid Probate	YES	Not Important
Ease of Administration during lifetime	YES	Not Important
Ease of Administration after death	YES	Not Important
Creditor Protection for Beneficiaries	YES	Not Important
Planning for a Child/Beneficiary with Special Needs	YES	Not Important

Other: ____

____

____

____

PERSONAL INFORMATION

Legal Name of Husband: ______________________________

Also Known as: ______________________________

Date of Birth: ______________________________

Email Address: ______________________________

Phone Number: ______________________________

Legal Name of Wife: ____

Also Known as: ____

Date of Birth: ____

Email Address: ____

Phone Number: ____

Date of Marriage: ____

Mailing Address: ____

____

Children in common:

Name: ______________________________

Phone Number: ______________________________

Date of Birth: ______________________________

Gender: ______________________________

Email Address: ______________________________

Name: ______________________________

Phone Number: ______________________________

Date of Birth: ______________________________

Gender: ______________________________

Email Address: ______________________________

Name: ______________________________

Phone Number: ______________________________

Date of Birth: ______________________________

Gender: ______________________________

Email Address: ______________________________

Children of Husband:

Name: ____

Phone Number: ________________________________

Date of Birth: _________________________________

Gender: ______________________________________

Email Address: ________________________________

Name: ____

Phone Number: ________________________________

Date of Birth: _________________________________

Gender: ______________________________________

Email Address: ________________________________

Children of Wife:

Name: ____

Phone Number: ________________________________

Date of Birth: _________________________________

Gender: ______________________________________

Email Address: ________________________________

Name: ____

Phone Number: ________________________________

Date of Birth: _________________________________

Gender: ______________________________________

Email Address: ________________________________

IMPORTANT FAMILY INFORMATION

Question	Yes	No
Are you or your spouse receiving Social Security Disability Benefits (answer No if you are only receiving Social security Retirement benefits) or AHCCCS?		
Are you or your spouse making payments pursuant to a divorce decree, child support order, or property settlement agreement or order?		
Are you or your spouse the beneficiary of anyone else's estate plan (Will or Trust)?		
Do any of your children or named beneficiaries have special education, medical or physical needs?		
Do any of your children or named beneficiaries receive government benefits, like AHCCCS, SSI or Medicaid?		
Do you or your spouse have any deceased children?		

What is the best way for us to provide drafts to you?

_____ EMAIL

_____ MAIL

_____ CALL when they are ready, and I will pick them up

QUESTIONS RELATED TO POWER OF ATTORNEY DOCUMENTS

POWER OF ATTORNEY FOR *FINANCIAL DECISIONS* FOR *HUSBAND*

(Person who makes financial decisions for you if you are unable.)

Husband's Designation Of Agent. Spouse: YES NO

If No:

Name: ____

Relationship: ___________________________________

Telephone Number: _______________________________

Email Address: __________________________________

Alternate Agent (in the event the spouse or other named person is unable or unwilling to act):

Name: ____

Relationship: ___________________________________

Telephone Number: _______________________________

Email Address: __________________________________

Effective Date (check one):

Should this Power of Attorney become effective: Immediately Upon Disability

Compensation (check one):

Should your agent be compensated for acting as your agent: Yes No

Gifts (check one):

Is it ok for your agent to give gifts of your money, during your lifetime? Yes No

POWER OF ATTORNEY FOR *FINANCIAL DECISIONS* FOR *WIFE*

(Person who makes financial decisions for you if you are unable.)

Wife's Designation Of Agent. Spouse: YES NO

If No:

Name: ____

Relationship: ________________________________

Telephone Number: ____________________________

Email Address: _______________________________

Alternate Agent (in the event the spouse or other named person is unable or unwilling to act):

Name: ____

Relationship: ________________________________

Telephone Number: ____________________________

Email Address: _______________________________

Effective Date (check one):

Should this Power of Attorney become effective: Immediately Upon Disability

Compensation (check one):

Should your agent be compensated for acting as your agent: Yes No

Gifts (check one):

Is it ok for your agent to give gifts of your money, during your lifetime? Yes No

POWER OF ATTORNEY FOR *HEALTH CARE* FOR *HUSBAND*

(Person who makes health care decisions for you, in the event you are unable to do so.)

Husband's Designation Of Healthcare Agent. Spouse: YES NO

If No:

Name: ____

Relationship: _______________________________________

Telephone Number: ________________________________

Email Address: _____________________________________

Alternate Agent (in the event the spouse or other named person is unable or unwilling to act):

Name: ____

Relationship: _______________________________________

Telephone Number: ________________________________

Email Address: _____________________________________

Do you want your Agent to be able to consent to donate your organs after your death (check all that apply)?

Yes: Any Medical Purpose; only Transplantation **OR** No

Do you have a preference for (check one): Cremation **OR** Burial

Any specific instructions: ____

____

My Health Care Power of Attorney may make Mental Health decisions for me, including placing me in a locked behavioral health care center (check one): YES NO

END OF LIFE DECISIONS FOR *HUSBAND*

In the event you are in a persistent vegetative state, coma or some other condition from which it is

unlikely you will recover, do you want:

Food and fluid by tube or intravenous to be continued (check one)? YES NO

Ventilator (check one)? YES NO

Dialysis Treatment (check one)? YES NO

Only Comfort Care (check one)? YES NO

Are there any specific instructions you want conveyed in your document? ____________________

____

____.

We strongly recommend providing the Health Care Power of Attorney document and the Living Will to your physician(s). If you would like us to mail a copy to your physician(s), please provide the name and contact information for each such physician.

Name of Doctor: ____

Address: ____

Telephone Number: ____

Name of Doctor: ____

Address: ____

Telephone Number: ____

POWER OF ATTORNEY FOR *HEALTH CARE* FOR *WIFE*

(Person who makes health care decisions for you, in the event you are unable to do so.)

Wife's Designation Of Healthcare Agent. Spouse: YES NO

If No:

Name: ____

Relationship: ______________________________________

Telephone Number: _________________________________

Email Address: _____________________________________

Alternate Agent (in the event the spouse or other named person is unable or unwilling to act):

Name: ____

Relationship: ______________________________________

Telephone Number: _________________________________

Email Address: _____________________________________

Do you want your Agent to be able to consent to donate your organs after your death (check all that apply)?

Yes: Any Medical Purpose; only Transplantation **OR** No

Do you have a preference for (check one): Cremation **OR** Burial

Any specific instructions: ____

____

My Health Care Power of Attorney may make Mental Health decisions for me, including placing me in a locked behavioral health care center (check one): YES NO

END OF LIFE DECISIONS FOR *WIFE*

In the event you are in a persistent vegetative state, coma or some other condition from which it is

unlikely you will recover, do you want:

Food and fluid by tube or intravenous to be continued (check one)? YES NO

Ventilator (check one)? YES NO

Dialysis Treatment (check one)? YES NO

Only Comfort Care (check one)? YES NO

Are there any specific instructions you want conveyed in your document? ____________________

____

____.

We strongly recommend providing the Health Care Power of Attorney document and the Living Will to your physician(s). If you would like us to mail a copy to your physician(s), please provide the name and contact information for each such physician.

Name of Doctor: ____

Address: ____

Telephone Number: ____

Name of Doctor: ____

Address: ____

Telephone Number: ____

TRUST/WILL

Many people choose to have a Trust, if they have property outside the State of Arizona, have minor children, have beneficiaries (children or others) who have special needs and may rely on some government benefits for health care, want to protect the inheritance from the divorce of a child, want distributions made over time, rather than outright upon death of the second of you or for other reasons. We will discuss these issues when you come in to determine if a Trust or a Will is the best option. ***If a Trust is created, what would you like the Trust name to be***?

____

DISTRIBUTIONS

To whom do you want your estate distributed after you pass away and in what percentages?

____

____

____

If we are drafting a Trust, do you want the beneficiaries to receive their allocation in a lifetime protection trust? YES NO

If not, at certain ages? For example, ½ at age 25 and the rest at age 30.

____

____

____

Which beneficiary will require a Special Needs Trust?

____

What if those person(s) were no longer living, who should receive your assets? (ex. Charity, siblings, parents, friends): Please include the person's name and their relationship to you or spouse.

____

____

____

How should your personal property (artwork, furniture, jewelry) be distributed?

____

____

____

Do you have any minor or special needs children that require a guardian or conservator (check one)? YES NO

If Yes, who do you want appointed as guardian of the children?

____

Do you have any beneficiaries with special needs that may require government assistance to cover health care (such as AHCCCS) (check one)? YES NO

Do you have any pets for which we need to make arrangements (i.e. someone to care for the pet and funds to be left to an individual or institution for the care of the animal(s)) (check one)?

YES NO

If Yes, what arrangements shall be made: _______________________________________

____

____

____

Who will settle your estate or act as the Trustee of your Trust (is it the same person who you

designated as your Financial Power of Attorney)? ______________________________________

____

Are you both citizens of the United States (check one)? YES **OR** NO

If no, who is not a citizen (this may have tax implications)? ______________________________

Do you own any real property other than the primary residence, including time shares?

YES **OR** NO

If Yes, please provide addresses of all property below and bring a copy of any deeds you can locate, including those for any timeshares.

____

____

____

Advisors

Name of Financial Advisor:____

Address: ____

____

Phone Number: ____

Email Address: ____

Is it acceptable to communicate with your Financial Advisor and provide a copy of your estate planning documents to him/her? YES NO

Name of CPA/Accountant:____

Address: ____

____

Phone Number: ____

Email Address: ____

Is it acceptable to communicate with your CPA/Accountant and provide a copy of your estate planning documents to him/her? YES NO

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS WORKSHEET.