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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

Name of Client: _____

Also Known as: _____

Date of Birth: _____

Email Address: _____

Phone Number: _____

Address: _____

**Children**:

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: _____

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 receiving Social Security Disability Benefits (answer No if you are only receiving Social security Retirement benefits) or AHCCCS? | ☐ | ☐ |
| Are you making payments pursuant to a divorce decree, child support order, or property settlement agreement or order? | ☐ | ☐ |
| Are you 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 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*

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

**Client's** Designation Of 1st Financial Agent:

Name: _____

Relationship: _____

Telephone Number: _____

Email Address: _____

**Alternate Agent** (in the event the first agent 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*

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

**Client's** Designation Of 1st Healthcare Agent:

Name: _____

Relationship: _____

Telephone Number: _____

Email Address: _____

**Alternate Agent** (in the event the first agent 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

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.

_____

_____

_____

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.

_____

_____

_____

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 a citizen of the United States (check one)? ☐ YES **OR** ☐ NO
(If Yes, 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.