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ATTORNEYS AT LAW

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CONFIDENTIAL LEGAL PLANNING INFORMATION

PLEASE FILL OUT THIS FORM TO THE BEST OF YOUR ABILITY BEFORE OUR SCHEDULED MEETING. Not all questions will apply to you. Do your best, but don't worry if some of the information you need to complete this form is not available to you. This information will be held in the strictest confidence.

Scheduled initial meeting: Date: _____ Time: _____

Referral Source: _____

1. Personal Information

Your Name: _____

Address: _____

Phone: _____ Email: _____

County: _____ SSN: _____

Date of birth: _____ Place of birth: _____

U.S. citizen?: Yes No Veteran?: Yes No

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

Prior Marriage Information:

Date of marriage: _____

Place of marriage: _____

If your last marriage ended by divorce:

Date of divorce: _____

Place of divorce: _____

If your last marriage ended by the death of your spouse:

Date of death: _____

Place of death: _____

Was a spouse/former spouse a Veteran? Yes No

2. Children

Name: _____
Address: _____
Phone: _____
Email: _____
Date of Birth: _____
Spouse: _____
Children: _____

Name: _____
Address: _____
Phone: _____
Email: _____
Date of Birth: _____
Spouse: _____
Children: _____

Name: _____
Address: _____
Phone: _____
Email: _____
Date of Birth: _____
Spouse: _____
Children: _____

Name: _____
Address: _____
Phone: _____
Email: _____
Date of Birth: _____
Spouse: _____
Children: _____

Name: _____
Address: _____
Phone: _____
Email: _____
Date of Birth: _____
Spouse: _____
Children: _____

Name: _____
Address: _____
Phone: _____
Email: _____
Date of Birth: _____
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?: _____

Are any of your grandchildren receiving Supplement Security Income, Social Security Disability; or, if not, has any major disabilities? Yes No

If yes, who?: _____

3. Information About Your Health

Please provide the following information:

Your height: _____

Your weight: _____

Do you smoke?: Yes No

If quit, when?: _____

Medication

Why are you taking this drug?

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What medical or health problems do you currently have (include date of diagnosis)?

- What medical problems have you had in the past?

- Please list hospitalizations in the past five years:

<u>Date</u>	<u>Why were you hospitalized?</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

- Family medical history (chronic illnesses such as Alzheimer’s or diabetes, etc.):

	<u>Your Mother</u>	<u>Your Father</u>
Chronic Illnesses:	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
Cause of death:	<hr/>	<hr/>
Age at death:	<hr/>	<hr/>
	<hr/>	<hr/>

- Name and contact information of your personal physician(s):

<u>Name</u>	<u>Address</u>	<u>Medical Specialty</u>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

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 Toilet			
Grooming			

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 transportation			
Preparing meals			
Doing housework or handyman work			
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"/>	Nursing home	
<input type="checkbox"/>	Other:	

List the names of all persons who provide assistance or care giving 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: _____

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: _____

List Total approximate value of “other assets”: _____

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

Do you have a prepaid funeral or burial? Yes No

If yes, describe the arrangements: _____

Other Insurance (Please complete the following health insurance information as it applies)

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: _____

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 items	
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:	
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, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, 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: _____

10. Estate Planning

Do you have any of the following documents?

- Durable Power of Attorney Yes No
- Health Care Power of Attorney Yes No
- Living Will Yes No
- Will Yes No
- Revocable Living Trust Yes No

Please provide your existing documents prior to our meeting.

Last Will:

Upon my death, I want to give...

- Everything to my children in equal shares **OR**

Alternative #1

- 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 _____.

Alternative #2

- Everything to my children and to my deceased spouse's children in equal shares.

Alternative #3

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
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

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/Zip: _____
Relationship: _____
Telephone number: _____

2. Name: _____
Address: _____
City/State/Zip: _____
Relationship: _____
Telephone number: _____

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/Zip: _____
Relationship: _____
Telephone number: _____

2. Name: _____
Address: _____
City/State/Zip: _____
Relationship: _____
Telephone number: _____

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/Zip: _____
 Relationship: _____
 Telephone number: _____

- 2. Name: _____
 Address: _____
 City/State/Zip: _____
 Relationship: _____
 Telephone number: _____

Springing versus Immediate Effectiveness: Do you want the authority of your attorney-in-fact for health care decisions (your health care agent) to be effective only upon proof of your disability as certified by your physicians (“Springing”) or effective immediately?

Springing Immediate

Do you want to be an organ donor? Yes No

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

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/Zip: _____
 Relationship: _____
 Telephone number: _____

- 2. Name: _____
 Address: _____
 City/State/Zip: _____
 Relationship: _____
 Telephone number: _____

Springing versus Immediate Effectiveness: Do you want the authority of your attorney-in-fact for financial decisions to be effective only upon proof of your disability as certified by your physician (“Springing”) or effective immediately?

Springing Immediate

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: _____
-
-

Fiduciary/Other Legal

I am the legally appointed guardian of: _____

I am serving as power of attorney for: _____

I am serving as executor or administrator of an estate Yes No

I am involved in a lawsuit Yes No

Please bring to our office or mail, or fax copies of this completed questionnaire and the following documents to our office prior to meeting with Lynn St. Louis:

1. Will, Codicil, Trust Agreements;
2. Real Estate Deeds, Appraisals
3. Admission Agreements to hospitals and health facilities
4. Divorce decrees, Pre-nuptial Agreements, Adoption Papers
5. Guardianship documents
6. Living Will, Health Care Directive
7. Durable Powers of Attorney for Financial and Health
8. A list of full names, addresses, telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries or your estate, helpers, and advisors
9. Retirement plans, including any forms designating beneficiaries
10. Life Insurance policies, including any forms designation beneficiaries