
CONFIDENTIAL CLIENT PROFILE
For Married Couple or Domestic Partners

The information requested on this worksheet helps us understand your situation and wishes for the future. Your time investment in this worksheet ensures that our time together is productive and that action can be taken quickly to design and implement your long-term care plan.

This worksheet is divided into three parts and may have additional addendums. The first part is personal information. The second part, Property Information, asks for information about your assets and liabilities. The third part, The People We Trust, asks you to list individuals who will be named to act on your behalf in financial and medical matters when you are no longer able. You should fill out the worksheet in as much detail as possible.

Please provide information on this worksheet for the person who needs long-term care planning. In other words, if you have contacted us to discuss your parent's situation, please complete this worksheet as if your parents had done so.

*All information provided is strictly **confidential** and protected by a legal privilege.*

Please complete and return this Profile to our office as soon as possible.



ABOUT US

Date: _____

Client's Legal Name _____ aka _____

Home Address _____

Mailing Address _____ Driver's License #/Exp: _____

Residence County _____ Home Phone _____ E-mail: _____

Birth date _____ SS# _____ US Citizen? _____ INS Status:* _____

Previously Married? Date of Divorce or Death of Spouse: _____

Spouse's Legal Name _____ aka _____

Birth date _____ SS# _____ US Citizen? _____ INS Status:* _____

Marriage Date _____ Ailment (if any) _____

Previously Married? Date of Divorce or Death of Spouse: _____

Your Name (if not Client): _____ Relationship to Client _____

Best times / place to reach me _____ It is okay to communicate with us via E-mail.

* If you are not a U.S. citizen, please provide our office with copies of your passport and, if applicable, your visa or other residency documents.

OUR CHILDREN AND/OR OTHER FAMILY MEMBERS

Use full legal name. Comments might be: physical or emotional disability, eligibility questions for government benefits, problems with substance abuse, marital strife, irresponsibility or other concerns.

Name	Birth date	Social Security #
1. _____	_____	_____
Parent: <input type="checkbox"/> Both of Us <input type="checkbox"/> Client <input type="checkbox"/> Spouse	Comments: _____	
2. _____	_____	_____
Parent: <input type="checkbox"/> Both of Us <input type="checkbox"/> Client <input type="checkbox"/> Spouse	Comments: _____	
3. _____	_____	_____
Parent: <input type="checkbox"/> Both of Us <input type="checkbox"/> Client <input type="checkbox"/> Spouse	Comments: _____	

If you have more loved ones, please use the reverse side to provide information about them.

ADVISORS

Name	Telephone
Personal Attorney _____	_____
Accountant _____	_____
Financial Advisor _____	_____
Life Insurance Agent _____	_____

Please sign here if I have your permission to contact your other advisors:

X _____

INCOME VERIFICATION

Please describe the source and timing of all payments that you receive (including Social Security, Retirement and Pension)

Name on Check/Payee	Source	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YOUR GOALS & CONCERNS

Please rate the following goals and concerns on a scale from 1 to 5. Your most important goals and concerns should be scored as "1", while a score of "5" will tell me that you are not concerned about that particular goal.

	Rating				
	1	2	3	4	5
<i>Financial Goals</i>					
Arrange your affairs and create a comprehensive plan to manage affairs in case of death or disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Become eligible for Medi-Cal immediately to cover skilled nursing home costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protecting your assets from recovery by state and federal government	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Estate and death taxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding probate, will contests or other disputes among family members after your death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protecting your assets from lawsuits or creditors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of an ongoing business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for the transfer and survival of a family business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preserving the privacy of your affairs in case of disability or at the time of your death from the courts, business competitors, predators, dishonest persons and curiosity seekers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduce administration costs at time of your death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Family Goals</i>					
Ensuring that your family has sufficient financial resources in case of your death or disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide for your children from a prior relationship in a blended family situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide for and protecting children or grandchildren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan for the care and maintenance of a child with special needs or disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protect your child/grandchild's inheritance from the possibility of a failed marriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protect your child/grandchild's inheritance in the event of a surviving spouse's remarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disinheriting a family member; preventing a relative from handling your affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Personal Goals</i>					
Charitable giving during life or at death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding court proceedings in the event of your disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding placement in a nursing home, assisted living facility or other institution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ensuring that your wish to accept or reject medical treatment is honored	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning in advance for your memorial services, funeral or the disposition of your remains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preserving your eligibility for government benefits (i.e. social security, disability, or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any other goals or concerns you may have in the space below or on the reverse side.

HAVE EITHER OF YOU:

- | | | |
|--|--------------------------|--------------------------|
| Completed previous will, trust, or estate planning? <i>If so, please attach copies of these documents.</i> | YES | NO |
| Signed a pre- or post-marriage contract? <i>If so, please furnish a copy.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever filed federal or state gift tax returns? <i>If so, please attach copies of these documents.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been widowed in a prior marriage? | <input type="checkbox"/> | <input type="checkbox"/> |

If a federal or state estate/death tax return was filed, please furnish a copy.

ARE EITHER OF YOU CURRENTLY:

- | | | |
|---|--------------------------|--------------------------|
| Receiving social security, disability, or other governmental benefits? <i>If so, please describe below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Making payments pursuant to a divorce or property settlement order? <i>If so, please provide a copy.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| The beneficiary of anyone else's trust? <i>If so, please explain below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| The owner of or have control over a Foreign Bank Account? <i>If so, please provide a copy of the statement.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Supporting any charities now that you wish to continue after your death? <i>If so, please explain below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Planning to make charitable gifts upon your death? <i>If so, please describe below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

DO:

- | | | |
|--|--------------------------|--------------------------|
| Any of your children have special educational, medical, or physical needs? <i>If so, please describe below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| Any of your children receive governmental support benefits? <i>If so, please describe below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| You provide primary or other major financial support to an Adult or others? <i>If so, please describe below.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

PROPERTY INFORMATION

This Property Information checklist is designed to help you list all the property you own and what it is worth. If you do not own property under a particular heading, just leave that section blank. Under certain headings you may own more property than can be listed in the space provided. If so, use extra sheets of paper to list your additional property.

TITLE ON YOUR ASSETS

How you hold title to your assets is extremely important in determining how to best manage that property in the context of your estate and long-term care plan. Please use the initials of the owner and the following designations when listing the "Owner."

- CP** Community property, which is property acquired by one or both spouses while married to each other.
- S** For property owned by an unmarried individual, or one spouse prior to marriage and kept **separate** from marital property.
- JTS** Joint tenancy between spouses and no other person.
- JTO** Joint tenancy with another person besides your spouse.

REAL ESTATE

TYPE: *Any interest in real estate including your family residence, vacation home, time share, vacant land, etc.*

Address	Type	Market Value	Mortgage	Equity
Total				

Please attach copies of deeds and mortgage information.

FURNITURE & PERSONAL PROPERTY

TYPE: List separately only major personal effects such as, jewelry, collections, antiques, furs, and all other valuable non-business personal property (indicate type below and **give a lump sum value for miscellaneous, less valuable items.**)

Type or Description	Owner	Market Value
Miscellaneous Furniture and Household Effects (Total)		
Total		

AUTOMOBILES, BOATS & RECREATIONAL VEHICLES

TYPE: For each motor vehicle, boat, ATV, RV, etc. please list the following: description, how titled, market value and encumbrance:

Type or Description	Owner	Market Value	Loan	Equity
Total				

MONEY OWED TO YOU

TYPE: Mortgages or promissory notes payable **to you**, or other moneys owed to you.

Name of Debtor	Note Date	Maturity	Owed to	Value
Total				

BANK & SAVINGS ACCOUNTS

TYPE: Checking Account "CA", Savings Account "SA", Certificates of Deposit "CD", Money Market "MM" Do not include IRA's or 401(k)'s here. If Account is in your name for the benefit of a minor, please specify the minor's name. Please detail your interest in any foreign bank & investment accounts on the Foreign Assets Addendum.

Financial Institution	Type	Owner	Acct. Number	Value
Total				

INVESTMENT ACCOUNTS, STOCKS & BONDS

TYPE: List stocks and bonds. If held in a brokerage account, list the accounts, not the holdings. List tax-deferred/retirement assets below in "Retirement Plans" section.

Financial Institution	Type	Owner	Acct. Number	Value
Total				

RETIREMENT PLANS

TYPE: Tax-deferred retirement accounts, including IRA, 401(k), 403(b), Pension (P), Profit Sharing (PS), H.R. 10, etc.

Custodian (Financial institution)	Beneficiary	Type	Owner	Account Number	Value
Total retirement investments					

LIFE INSURANCE POLICES & ANNUITIES

TYPE: Term, whole life, split dollar, group life, annuity.

Insurance Company & Agent	Beneficiary	Insured	Owner	Contract #/Type	Face Value
Total coverage					

BUSINESS INTERESTS

TYPE: General and Limited Partnerships, Sole Proprietorships, privately owned corporations, professional corporations, oil interests, farm and ranch interests. Give a description of the interests, who has the interest, your ownership in the interests, and the estimated value of the interests.

Name and Type	Owner	Market Value
Total		

ANTICIPATED INHERITANCE, GIFT, OR LAWSUIT JUDGMENT

TYPE: Gifts or inheritances that you expect to receive at some time in the future; or moneys that you anticipate receiving through a judgment in a lawsuit. Describe in appropriate detail.

Description _____

Total estimated value _____

OTHER ASSETS

TYPE: Other property is any property that you have that does not fit into any listed category.

Description _____

Total estimated value _____

SUMMARY OF VALUES

For joint property held with someone other than a spouse, enter the value of the share owned by you or your spouse.

Assets	Total Value
Real Estate	
Furniture and Personal Property	
Automobiles, Boats & RVs	
Money Owed to You	
Bank and Savings Accounts	
Stocks and Bonds	
Life Insurance & Annuities	
Retirement Accounts	
Business Interests	
Anticipated Inheritance, Gift or Lawsuit Judgment	
Other	
Total	

THE PEOPLE WE TRUST

In designing your estate and long-term care plan, we need to know the names, addresses and telephone numbers of the individuals you will designate to act on your behalf in a number of different roles:

1. Financial decision-makers in the event of your incapacity or death
2. Health Care decision-makers in the event of your incapacity
3. Primary Care Physician, if you have one

Many times clients will name the same individuals to act on their behalf in a number of different capacities. Please think of alternate individuals for each role. If you know what role you want an individual to have, please note that below. Also, if any person that you wish to name is not a citizen of the United States of America, please designate the country of citizenship and their residency status.

CLIENT

Name, Address & Telephone	Relationship / Citizenship	Role
Tel:		Financial Decision-Makers: 1. _____ 2. _____ 3. _____ 4. _____ Medical Decision-Makers: 1. _____ 2. _____ 3. _____ 4. _____
Tel:		
Tel:		
Dr.: Clinic: Address: Tel:	Primary Care Physician	

SPOUSE

Name, Address & Telephone	Relationship / Citizenship	Role
Tel:		Financial Decision-Makers: 1. _____ 2. _____ 3. _____ 4. _____ Medical Decision-Makers: 1. _____ 2. _____ 3. _____ 4. _____
Tel:		
Tel:		
Dr.: Clinic: Address: Tel:	Primary Care Physician	