

# LONG TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

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CONFIDENTIAL  
LONG TERM CARE PLANNING QUESTIONNAIRE

JOSEPH L. MOTTA CO., LPA  
32730 Walker Road, Suite I-6  
Avon Lake, Ohio 44012  
phone: (440) 930-2826 fax: (440) 930-2896

DATE: \_\_\_\_\_

**SECTION 1. NAMES AND CONTACT INFORMATION**

Person Completing Form: \_\_\_\_\_  
(first) (middle) (last)

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Client's Full Name: \_\_\_\_\_  
(first) (middle) (last)

Client's Spouse Full Name: \_\_\_\_\_  
(first) (middle) (last)

Home Address: \_\_\_\_\_  
\_\_\_\_\_

**Client**

**Spouse**

Telephone Numbers: \_\_\_\_\_  
(home) (home)  
\_\_\_\_\_ (cell) (cell)

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

US Citizen?: [ ] Yes [ ] No [ ] Yes [ ] No

Veteran?: [ ] Yes [ ] No [ ] Yes [ ] No

Dates of Service: \_\_\_\_\_ Dates of Service: \_\_\_\_\_  
\_\_\_\_\_

**SECTION 2. MARITAL INFORMATION**

**A.** Date of Marriage: \_\_\_\_\_

**B.** Place of Marriage: \_\_\_\_\_  
(city) (state or province) (country)

**C. Client's Former Spouses:**

**1.** \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?)

**2.** \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?)

**D. Spouse's Former Spouses:**

**1.** \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?)

**2.** \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?)

**SECTION 3. CHILDREN**

List all children. Copy and attach additional pages, if needed.

Total number of children: \_\_\_\_\_

**1.** \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)  
Parent:  Client  Spouse  Both      Is Child Married?  Yes  No

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

**Adopted** \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)  
 **Deceased** \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
(Use additional pages, if needed)

**2.** \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)  
Parent:  Client  Spouse  Both      Is Child Married?  Yes  No

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

**Adopted** \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)  
 **Deceased** \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
(Use additional pages, if needed)

**3.** \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)  
Parent:  Client  Spouse  Both      Is Child Married?  Yes  No

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

**Adopted** \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)  
 **Deceased** \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
(Use additional pages, if needed)

4. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)

Parent:  Client  Spouse  Both      Is Child Married?  Yes  No

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)

Deceased \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
 (Use additional pages, if needed)

5. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)

Parent:  Client  Spouse  Both      Is Child Married?  Yes  No

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)

Deceased \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
 (Use additional pages, if needed)

6. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)

Parent:  Client  Spouse  Both      Is Child Married?  Yes  No

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)

Deceased \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
 (Use additional pages, if needed)

**SECTION 4. HEALTH-RELATED PROBLEMS**

Please describe any specific health-related problems.

**A. Client**

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**B. Spouse**

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**SECTION 5. CAPACITY**

**A. MEMORY AND UNDERSTANDING**

Are there any known problems with memory or understanding?

Client: [ ] Yes [ ] No

Spouse: [ ] Yes [ ] No

If yes, please explain:

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**B. OTHER ISSUES**

	<b><u>Client</u></b>	<b><u>Spouse</u></b>
Able to sign name?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to speak?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to recognize friends and family?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Cognizant of property and possessions?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to leave current residence?:	[ ] Yes [ ] No	[ ] Yes [ ] No

**SECTION 6. PHYSICIAN INFORMATION**

Please list the name, specialty, address, and phone number of your primary physician.

<b><u>Client</u></b>	<b><u>Spouse</u></b>
Physician's Name: _____	_____
Specialty: _____	_____
Address: _____	_____
_____	_____
Business Phone: _____	_____

**SECTION 7. LONG TERM CARE (LTC)**

**A. Client**

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: \_\_\_\_\_

Name of Facility/Provider: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Business Phone: \_\_\_\_\_

Administrator or Contact: \_\_\_\_\_

**B. Spouse**

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: \_\_\_\_\_

Name of Facility/Provider: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Business Phone: \_\_\_\_\_

Administrator or Contact: \_\_\_\_\_

**SECTION 8. HOSPITAL**

**A. Client**

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: \_\_\_\_\_

Name/location of hospital: \_\_\_\_\_

Description of medical issue: \_\_\_\_\_

\_\_\_\_\_

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

**B. Spouse**

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: \_\_\_\_\_

Name/location of hospital: \_\_\_\_\_

Description of medical issue: \_\_\_\_\_

\_\_\_\_\_

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No



**SECTION 9. INCOME**

In completing the following section, use the “name on the check” rule; that is, the person whose name appears on the payment is the “owner” of the income.

**A. FIXED MONTHLY INCOME**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Social Security:	\$ _____	\$ _____	\$ _____
2. R.R. Retirement:	\$ _____	\$ _____	\$ _____
3. Pension:	\$ _____	\$ _____	\$ _____
4. _____:	\$ _____	\$ _____	\$ _____
5. _____:	\$ _____	\$ _____	\$ _____
6. _____:	\$ _____	\$ _____	\$ _____

**B. NON-FIXED MONTHLY INCOME**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Interest:	\$ _____	\$ _____	\$ _____
2. Dividends:	\$ _____	\$ _____	\$ _____
3. _____:	\$ _____	\$ _____	\$ _____
4. _____:	\$ _____	\$ _____	\$ _____
5. _____:	\$ _____	\$ _____	\$ _____

<b>C. TOTALS (A thru B):</b>	<b>\$ _____</b>	<b>\$ _____</b>	<b>\$ _____</b>
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**SECTION 10. ASSETS AND RESOURCES**

**A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)**

**(Please provide copies of statements)**

<u>Name of Bank/Branch</u>	<u>Account No.</u>	<u>Type of Account</u>	<u>Balance/Value</u>	<u>How Title Held</u>
Big Bank/Main St. <small>(example)</small>	xxx-xxxx	Savings	\$ xx,xxx.xx	Client
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____

**B. BROKERAGE ACCOUNTS**

**(Please provide copies of statements)**

<u>Name of Investment Firm</u>	<u>Account No.</u>	<u>Account Value</u>	<u>How Title Held</u>
Big Broker <small>(example)</small>	xxx-xxxx	\$ xx,xxx.xx	Spouse
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

**C. SECURITIES (Bonds, Marketable Securities, etc.)**

**(Please provide copies of statements)**

<u>Name of Company</u>	<u>Type of Sec.</u>	<u># Shares</u>	<u>Cost</u>	<u>Current Val.</u>	<u>How Title Held</u>
Acme Corp. <small>(example)</small>	Common Stock	xx Shares	\$ x,xxx.xx	\$ x,xxx.xx	Jointly
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____

**D. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)**

(Please provide copies of statements and beneficiary designations)

<u>Name of Institution</u>	<u>Account No.</u>	<u>Owner</u>	<u>Beneficiary</u>	<u>Date Est.</u>	<u>Current Value</u>
Big Broker (example)	xxx-xxxx	Client	Spouse	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

**E. LIFE INSURANCE POLICES**

(Please provide copies of policies and beneficiary designations)

<u>Name of Company</u>	<u>Policy No.</u>	<u>Owner</u>	<u>Insured</u>	<u>Beneficiary</u>	<u>Face Amount</u>	<u>Cash Value</u>
Premier Insurance Co. (example)	xxx-xxxx	Client	Client	Spouse	\$100,000.00	
_____	_____	_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	_____	_____	\$ _____	\$ _____

**F. ANNUITY CONTRACTS**

(Please provide copies of contracts and beneficiary designations)

<u>Name of Company</u>	<u>Contract No.</u>	<u>Owner</u>	<u>Annuitant</u>	<u>Beneficiary</u>	<u>Current Value</u>
Premier Insurance Co. (example)	xxx-xxxx	Client	Client	Spouse	\$100,000.00
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

**G. REAL ESTATE (Other than Residence)**

(Please provide copies of deeds and most recent tax bills)

<u>Description (Location)</u>	<u>Cost (Basis)</u>	<u>Market Value</u>	<u>Mortgage Bal.</u>	<u>How Title Held</u>
123 Know Way (sample)	\$ xxx,xxx.xx	\$ xxx,xxx.xx	\$ xx,xxx.xx	Joint tenant
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____

**H. PERSONAL PROPERTY**

	<u>Market Value</u>	<u>How Title Held</u>
Car 1:	\$ _____	_____
Car 2:	\$ _____	_____
Boat	\$ _____	_____
RV/Camper	\$ _____	_____
_____	\$ _____	_____
(other: collectibles, etc.)	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

**I. BUSINESS INTERESTS**

If Client or Spouse has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

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**J. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES**

Briefly describe or give the name of the Trust in which Client or Spouse has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

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**K. MISCELLANEOUS**

If Client or Spouse has any property interests not described above, please explain the nature of the interests and the estimated value of each.

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**SECTION 11. RESIDENCE -- OWNED**

A. How is title held? \_\_\_\_\_

*PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL*

B. Fair Market Value:       \$ \_\_\_\_\_

C. Mortgage Balance:       \$ \_\_\_\_\_

D. Single Family Residence? [ ] Yes [ ] No

E. If the property was purchased, please provide the following:

1. Date of Purchase: \_\_\_\_\_

2. Purchase Price: \$ \_\_\_\_\_

**F.** If the property was inherited, please provide the following:

1. Month/Year Inherited: \_\_\_\_\_
2. Value when Inherited: \$ \_\_\_\_\_

**G.** If at least one occupant of the residence is a child of the individual in need of long term care, has that child lived in the residence for at least 2 years?  Yes  No

1. If yes, has the child provided personal care to the parent that might have delayed the need for long term care for the parent?  Yes  No
2. If so, please describe the nature and duration of the care provided:

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**H.** Does the person needing care have any living children who are disabled?  Yes  No

If yes, please describe the nature of the disability:

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**I.** Does the owner have a sibling who has lived in the house for at least 1 year?  Yes  No

If yes, does the sibling still reside in the home?  Yes  No

### **SECTION 12. RESIDENCE -- RENTED**

**A.** Monthly Rent: \$ \_\_\_\_\_

**B.** Type of Rental:  Single Family  Apartment  Residential Care  Life Care  
 Senior Housing

**C.** Rental/Lease Agreement?  Yes  No

**D.** Is Rent Subsidized?  Yes  No

If so, by whom and amount? \_\_\_\_\_

**SECTION 13. MONTHLY COST OF LIVING**

**A. HOUSING (ESTIMATED PER MONTH)**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. If home is owned:			
mortgage:	\$ _____	\$ _____	\$ _____
property taxes:	\$ _____	\$ _____	\$ _____
homeowner assoc. dues:	\$ _____	\$ _____	\$ _____
insurance:	\$ _____	\$ _____	\$ _____
water and sewer:	\$ _____	\$ _____	\$ _____
electricity:	\$ _____	\$ _____	\$ _____
gas:	\$ _____	\$ _____	\$ _____
telephone:	\$ _____	\$ _____	\$ _____
2. If home is rented:			
monthly rent:	\$ _____	\$ _____	\$ _____
electricity:	\$ _____	\$ _____	\$ _____
gas:	\$ _____	\$ _____	\$ _____
water and sewer:	\$ _____	\$ _____	\$ _____
_____:	\$ _____	\$ _____	\$ _____
(other)			

**B. HEALTH INSURANCE PREMIUMS (PER MONTH)**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Health insurance:	\$ _____	\$ _____	\$ _____
2. Long term care insurance:	\$ _____	\$ _____	\$ _____
3. _____:	\$ _____	\$ _____	\$ _____
(specify)			
4. _____:	\$ _____	\$ _____	\$ _____
(specify)			

**C. MEDICAL EXPENSES NOT COVERED BY INSURANCE (ESTIMATED PER MONTH)**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Non-covered medications:	\$ _____	\$ _____	\$ _____
2. _____ : (specify)	\$ _____	\$ _____	\$ _____
3. _____ : (specify)	\$ _____	\$ _____	\$ _____
4. _____ : (specify)	\$ _____	\$ _____	\$ _____

**D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Food:	\$ _____	\$ _____	\$ _____
2. Clothing:	\$ _____	\$ _____	\$ _____
3. Entertainment and travel:	\$ _____	\$ _____	\$ _____
4. Support for children:	\$ _____	\$ _____	\$ _____
5. _____ : (specify)	\$ _____	\$ _____	\$ _____
6. _____ : (specify)	\$ _____	\$ _____	\$ _____
<b>E. TOTALS (A thru D):</b>	<b>\$ _____</b>	<b>\$ _____</b>	<b>\$ _____</b>

**SECTION 14. HEALTH AND LTC INSURANCE**

If Client or Spouse has Medicare Parts A, B, or D, private health or long term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

<u>Name of Insurer</u>	<u>Policy No.</u>	<u>Type of Policy</u>	<u>Monthly Prem.</u>	<u>If LTC, Daily Benefit</u>
Premier Insurance Co. (example)	xxx-xxxx	Long term care	\$500.00	\$100.000
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____



**SECTION 15. TRANSFERS WITHIN 5 YEARS**

Has Client or Spouse transferred property to someone other than his or her spouse within the past five (5) years? If so, please provide the following information and **copies of gift tax returns, if available**:

**A. Client**

<u>Recipient</u>	<u>Amount/Value of Gift</u>	<u>Date of Gift</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____
4. _____	\$ _____	_____

**B. Spouse**

<u>Recipient</u>	<u>Amount/Value of Gift</u>	<u>Date of Gift</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____
4. _____	\$ _____	_____

**SECTION 16. TRANSFERS TO OR FROM TRUSTS**

Has Client or Spouse transferred property into a Trust, or directed that property be transferred from a Trust within the past five (5) years? If so, please provide the following information:

**A. Client**

<u>Name of Trust</u>	<u>Amount/Value of Transfer</u>	<u>Date of Transfer</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____

**B. Spouse**

<u>Name of Trust</u>	<u>Amount/Value of Transfer</u>	<u>Date of Transfer</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____

**SECTION 17. ESTATE PLANNING AND OTHER DOCUMENTS**

Please indicate if you have any of the following documents, and if so provide a copy of each.

	<u>Client</u>	<u>Spouse</u>
Will:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pour-Over Will:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
General Durable Power of Attorney:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Power of Attorney (or Proxy):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 18. FUNERAL AND BURIAL CONTRACTS**

Please indicate whether Client or Spouse has the listed items.

	<u>Client</u>	<u>Spouse</u>
Burial plot:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irrevocable funeral contract:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 19. DISPOSITIVE PLANNING**

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, charities.

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

**Client:**

**A.** First-choice beneficiaries:  Spouse  Children  Spouse and Children  Other

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**B.** Second-choice beneficiaries:  Spouse  Children  Spouse and Children  Other

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**C.** Any specific disposition of your residence?

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**D.** Any specific gifts of special articles, such as art or jewelry?

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**E.** Any specific disposition of household and personal effects?

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**F.** Other information you think is important to your estate planning:

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**Spouse:**

**A.** First-choice beneficiaries:  Spouse  Children  Spouse and Children  Other

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**B.** Second-choice beneficiaries:  Spouse  Children  Spouse and Children  Other

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**C.** Any specific disposition of your residence?

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**D.** Any specific gifts of special articles, such as art or jewelry?

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**E.** Any specific disposition of household and personal effects?

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**F.** Other information you think is important to your estate planning:

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**SECTION 20. FIDUCIARIES**

Please consider who you want to handle your affairs when you cannot.

**CLIENT:**

**A. EXECUTOR**

**Initial Executor**

\_\_\_\_\_  
(name) \_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address) \_\_\_\_\_  
(phone number)

**Successor Executor**

\_\_\_\_\_  
(name) \_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address) \_\_\_\_\_  
(phone number)

**B. TRUSTEE**

**Initial Trustee**

\_\_\_\_\_  
(name) \_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address) \_\_\_\_\_  
(phone number)

**Successor Trustee**

\_\_\_\_\_  
(name) \_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address) \_\_\_\_\_  
(phone number)

**C. GUARDIAN OF MINOR CHILDREN**

**Initial Guardian**

\_\_\_\_\_  
(name) \_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address) \_\_\_\_\_  
(phone number)

**Successor Guardian**

\_\_\_\_\_  
(name) \_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address)

\_\_\_\_\_  
(phone number)

**D. AGENT UNDER POWER OF ATTORNEY**

**Initial Agent**

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address)

\_\_\_\_\_  
(phone number)

**Successor Agent**

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address)

\_\_\_\_\_  
(phone number)

**E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY**

**Initial Agent**

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address)

\_\_\_\_\_  
(phone number)

**Successor Agent**

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address)

\_\_\_\_\_  
(phone number)

**SPOUSE:**

**A. EXECUTOR**

**Initial Executor**

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(relationship)

\_\_\_\_\_  
(current address)

\_\_\_\_\_  
(phone number)

**Successor Executor**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**B. TRUSTEE**

**Initial Trustee**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**Successor Trustee**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**C. GUARDIAN OF MINOR CHILDREN**

**Initial Guardian**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**Successor Guardian**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**D. AGENT UNDER POWER OF ATTORNEY**

**Initial Agent**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**Successor Agent**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY**

**Initial Agent**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)

**Successor Agent**

\_\_\_\_\_  
(name) (relationship)

\_\_\_\_\_  
(current address) (phone number)