ELDER LAW INTAKE FORM

Person completing this form:

Name _____ Relationship to Client (s) _____
Address _____ Phone (H) _____ (C) _____

Client Information

Please use the left column for the client from the client's perspective and the right column for his or her spouse or domestic partner.

Name _____
Other Names Used _____
Address _____
_____
Phone (H) _____ (C) _____
DOB _____ SSN _____
Birthplace _____
Citizenship _____
Military Veteran _____
_____
Number of children _____
Marital Status S M D W Sep
Date of Current Marriage _____
City, State Married _____
Number of children of this marriage _____
Prior Spouse(s):
Name _____
Deceased? _____ DOD _____
Number of children of this marriage _____
Do any children have major disabilities? _____
_____
Do they receive Suppl. Security Income/Medicaid? _____
Does anyone depend on you for support? _____
_____
Mother's age at death _____ Cause _____
Father's age at death _____ Cause _____
Do you plan to pay for a beneficiary's education? _____
Do you plan to pay for a beneficiary's wedding? _____
Do you plan to help a beneficiary buy a home? _____
Do you expect to care for an aging parent? _____
Is there a beneficiary with special needs? _____
Do you have long-term care insurance? _____
Do you have any of the following:
Will dated: _____
Trust dated: _____
Living Will dated: _____
Property Power of Attorney dated: _____
Healthcare Power of Attorney dated: _____
DNR dated: _____
Other dated: _____

Name _____
Other Names Used _____
Address _____
_____
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DOB _____ SSN _____
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Citizenship _____
Military Veteran _____
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Number of children _____
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Property POA dated: _____
Healthcare POA dated: _____
DNR dated: _____
Other dated: _____

Children

Please list your children starting with the eldest in the left column. Use the right column for any children of your spouse only.

Name ____
DOB __________ Mother ___________________________
Married? _______ Spouse __________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? ______

Name ____
DOB __________ Mother ___________________________
Married? _______ Spouse __________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? ______

Name ____
DOB __________ Mother ___________________________
Married? _______ Spouse __________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? ______

Name ____
DOB __________ Mother ___________________________
Married? _______ Spouse __________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? ______

Name ____
DOB _________________
Married? _______ Spouse __________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? _______

Name ____
DOB _________________
Married? _______ Spouse __________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? _______

Name ____
DOB _________________
Married? ______ Spouse ___________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? _______

Name ____
DOB ________________
Married? ______ Spouse ___________________________
Number of children ______________________________
Address ____
____
Phone (H) _________________ (C) _________________
May we talk to this person about you if needed? _______

____
____
____
____
____

Client's Health Information

Current health or medical problems _____
_____
_____

Past health or medical problems _____
_____
_____

Current Medications and reason for taking this drug:

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

Family history of health problems and who was afflicted:

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

Personal physicians:

Name _____ Specialty _____
Address _____
Phone _____ Hospital _____

Name _____ Specialty _____
Address _____
Phone _____ Hospital _____

Name _____ Specialty _____
Address _____
Phone _____ Hospital _____

Healthcare Decisions

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult about your care? Please give two choices in case your first choice is unable or unwilling to act.

First Choice:

Name _____ Relationship _____
Address _____
Phone _____ Email _____

Second Choice:

Name _____ Relationship _____
Address _____
Phone _____ Email _____

Functional Limitations

The phrase "activities of daily living" refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help from either other people or devices such as a walker or a wheelchair or both. The more assistance people need with their daily activities, the more likely they are to be admitted to a nursing home or other assisted living arrangement, or to use paid home care, or to need hospital care and doctors.

Check the column that best applies for each activity:

Activities of Daily Living	Needs No Help	Needs Some Help	Unable To Do At All
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding Self			
Using the toilet			
Grooming			

Instrumental Activities of Daily Living	Needs No Help	Needs Some Help	Unable To Do At All
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

Where do you live?	*Name*	*Since When?*
_____ Single-family home or Town home	_____	_____
_____ Same but someone assists you with the above activities	_____	_____
_____ Apartment in retirement living community	_____	_____
_____ Assisted living facility	_____	_____
_____ Nursing home	_____	_____
_____ Other	_____	_____

Please list the names of any persons providing assistance or care-giving for you:

_____

_____

Public Benefits and Community Services

In addition to Social Security and Medicare, are you receiving any other form 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, Tricare for Life, Meals on Wheels, subsidized transportation services, adult day care, support group services, property tax relief, and drug company discount programs. Please list any benefits below:

Provider	Form of Assistance
_____	_____
_____	_____
_____	_____

Income and Assets

Using the summary table below, please give your income and the approximate value of your assets. The first column is for assets owned solely by you or your living trust. The middle column is for assets owned solely by your spouse or your spouse's living trust. The third column is for assets titled jointly by both of you or in a joint living trust. The approximate value of each asset owned should appear in only one of the columns.

	Client	*Spouse*	*Joint*
Monthly Social Security income			
Monthly retirement income other than Soc. Sec.			
Monthly investment and other income			
Equity in Illinois real estate			
Equity in real estate not in Illinois			
Investments – non- retirement			
Ordinary bank accounts			
Life insurance death benefit			
Tangible personal property			
Business or trust property			
Vested retirement assets (lump sum payouts)			
Anticipated inheritances			
Powers of Appointment			
Other property			

Decision Making Preferences

Legal and Financial:

If you were unable to carry out your legal and financial business, who would you want to take care of your legal, business, financial, and personal affairs? These should be persons you trust completely to make appropriate decisions for your benefit. Please give at least two choices in case your first choice is unable or unwilling to act.

First Choice:

Name _____ Relationship _____

Address _____

Phone _____ Email _____

Second Choice:

Name _____ Relationship _____

Address _____

Phone _____ Email _____

Upon death:

Whom do you want to handle the administration of your estate after your death? Please give at least two choices in case your first choice is unable or unwilling to act.

First Choice:

Name _____ Relationship _____

Address _____

Phone _____ Email _____

Second Choice:

Name _____ Relationship _____

Address _____

Phone _____ Email _____

Do you have a prepaid funeral/burial or cemetery plot? _____ If yes, please describe the arrangements:

_____

Monthly Expenses

Item	*Amount*
Mortgage or rent	
Property tax	
Home maintenance and upkeep	
Utilities (gas, electric, water & sewer, security)	
Telephone	
Cable television	
Internet service	
Homeowners insurance	
Health insurance	
Medical expenses not reimbursed, such as for drugs	
Private health care services	
Life insurance	
Automobile	
Automobile insurance	
Automobile gas and maintenance	
Clothing	
Groceries and other household	
Haircuts, personal grooming	
Laundry and cleaning	
Bank account fees/charges	
Newspaper or magazine subscriptions	
Recreation, vacation, entertainment	
Charitable contributions	
Nursing home cost (paid by -)	
Prescription cost	
Other:	
Other:	
Other:	
Total	

Anticipated maintenance and/or improvements needed for your home. Examples include roof replacement, siding, windows, painting, repairs, driveway, etc.

Item	*Cost*
Total	

Debts

Creditor Name	*Amount owed*
Total	

Gifts and Transfers

Please list any gifts or transfers in excess of $500 to any individual, charity, or trust within the last 60 months.

To Whom ______________________________
Date of gift ______________________________
Item ______________________________
Value when made ______________________________
Current value ______________________________

To Whom ______________________________
Date of gift ______________________________
Item ______________________________
Value when made ______________________________
Current value ______________________________

To Whom ______________________________
Date of gift ______________________________
Item ______________________________
Value when made ______________________________
Current value ______________________________

To Whom ______________________________
Date of gift ______________________________
Item ______________________________
Value when made ______________________________
Current value ______________________________

In the past 60 months, have you paid money for someone else's benefit? Examples include paying for a child's wedding or grandchild's education, etc. __________

Does anybody owe you money? __________ If yes, who and how much? ______________________________

Have you lost any money gambling in the past five years? _________ If yes, when and how much? ______________

Have you ever filed a Federal Gift Tax Return? _________ If yes, when? ______________________________

Other Intended Beneficiaries and Fiduciaries

Please identify other individuals whom you will be naming either as beneficiaries or fiduciaries and any additional persons who may be involved with your planning or decision-making process. Include each person's relationship to you.

Name ______________________________
Relationship ______________________________
Address ______________________________
____
Phone (H) ______________ (C) ______________
May we talk to this person about you if needed? ______

Name ______________________________
Relationship ______________________________
Address ______________________________
____
Phone (H) ______________ (C) ______________
May we talk to this person about you if needed? ______

Name ______________________________
Relationship ______________________________
Address ______________________________
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Relationship ______________________________
Address ______________________________
____
Phone (H) ______________ (C) ______________
May we talk to this person about you if needed? ______

Name ______________________________
Relationship ______________________________
Address ______________________________
____
Phone (H) ______________ (C) ______________
May we talk to this person about you if needed? ______

Personal Advisors

Accountant ______________________________ ______________________________
Phone ______________________________ ______________________________

May we talk to this person about you if needed? _____

Life Insurance Agent _____
Phone _____
May we talk to this person about you if needed? _____

Financial Planner _____
Phone _____
May we talk to this person about you if needed? _____

Safe Deposit Box Information:
Bank Name _____
Branch _____
Box Number _____ Registered to _____
Signatories _____

May we talk to this person about you if needed? _____

_____
_____
May we talk to this person about you if needed? _____

_____
_____
May we talk to this person about you if needed? _____

_____
_____
_____
_____