



CONFIDENTIAL ESTATE PLANNING & ASSET PROTECTION WORKSHEET

This information packet should be returned to us at least three days prior to your meeting. This will ensure that we have enough time to understand the specifics of your situation before our meeting.

If you need assistance completing the information, call our office at 225-744-0027 and we will help you. Those questions that do not apply to you, your family or your financial information can simply be ignored.

DON'T WORRY ABOUT TOTAL ACCURACY – JUST DO THE BEST YOU CAN! WE LOOK FORWARD TO SEEING YOU.

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

CLIENT INFORMATION

Date: _____

Person Completing Form: _____
(first, middle/maiden and last)

Daytime Phone: _____ Fax _____

Mailing Address: _____

Alternate Phone: _____ Cell Phone _____

E-mail Address: _____

Date of Birth: _____ SSN: _____

Client Full Name (if different from above): _____
(first, middle/maiden and last)

Daytime Phone: _____ Fax _____

Mailing Address: _____

Alternate Phone: _____ Cell Phone _____

E-mail Address: _____

Military Service [] Yes [] No Dates of Service: _____

Date of Birth: _____ SSN: _____

Is Client: Married Widowed Divorced Single

Spouse's Full Name _____
(first, middle/maiden and last)

Daytime Phone: _____ Fax _____

Mailing Address: _____

Alternate Phone: _____ Cell Phone _____

E-mail Address: _____

Military Service [] Yes [] No Dates of Service: _____

Date of Birth: _____ SSN: _____

Marriage Date _____

How did you hear about our firm?

- Telephone book
- Ascension Magazine
- Attended Seminar
- Referred by Someone – please provide name _____
- Other - please specify _____
- Check this box if you do not wish to be added to our mailing list

ADVISORS

Personal Attorney _____

Phone: _____ Fax _____

Mailing Address: _____

Accountant _____

Phone: _____ Fax _____

Mailing Address: _____

Financial Advisor _____

Phone: _____ Fax _____

Mailing Address: _____

Life Insurance Agent _____

Phone: _____ Fax _____

Mailing Address: _____

CHILDREN AND/OR OTHER FAMILY MEMBERS

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

Total number of children: _____

1. _____
(name of child) (first, middle/maiden and last) (date of birth) (social security number)

(current address) (phone) Home Work Cell

Parent: Client Spouse Both

Is child: Married Widowed Divorced Single

Name of Spouse (if married): _____

Adopted _____
(date of adoption) (court granting adoption)

Deceased _____ Yes No
(date of death) (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) (first, middle/maiden and last) (date of birth) (social security number)

(current address) (phone) Home Work Cell

Parent: Client Spouse Both

Is child: Married Widowed Divorced Single

Name of Spouse (if married): _____

Adopted _____
(date of adoption) (court granting adoption)

Deceased _____ Yes No
(date of death) (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) (first, middle/maiden and last) (date of birth) (social security number)

(current address) (phone) Home Work Cell

Parent: Client Spouse Both

Is child: Married Widowed Divorced Single

Name of Spouse (if married): _____

Adopted _____
(date of adoption) (court granting adoption)

Deceased _____ Yes No
(date of death) (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) (first, middle/maiden and last) (date of birth) (social security number)

(current address) (phone) Home Work Cell

Parent: Client Spouse Both

Is child: Married Widowed Divorced Single

Name of Spouse (if married): _____

Adopted _____
(date of adoption) (court granting adoption)

Deceased _____ Yes No
(date of death) (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) (first, middle/maiden and last) _____ (date of birth) _____ (social security number)

_____ (current address) _____ (phone) Home Work Cell

Parent: Client Spouse Both

Is child: Married Widowed Divorced Single

Name of Spouse (if married): _____

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) (first, middle/maiden and last) _____ (date of birth) _____ (social security number)

_____ (current address) _____ (phone) Home Work Cell

Parent: Client Spouse Both

Is child: Married Widowed Divorced Single

Name of Spouse (if married): _____

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)

IMPORTANT FAMILY QUESTIONS

(Please check "Yes" or "No" for your answer)	Yes	No
Are you (or your spouse) receiving social security, disability, or other governmental benefits? <i>Describe</i> _____		
Are you (or your spouse) making payments pursuant to a divorce or property settlement order? <i>Please furnish a copy</i>		
If married have you and your spouse signed a pre- or post-marriage contract? <i>Please furnish a copy</i>		
Have you (or your spouse) been widowed? <i>If a federal estate tax return or a state death tax return was filed, please furnish a copy</i>		
Have you (or your spouse) ever filed federal or state gift tax returns? <i>Please furnish copies of these returns</i>		
Have (you or your spouse) completed previous will, trust, or estate planning? <i>Please furnish copies of these documents</i>		
Do you support any charitable organizations now that you wish to make provisions for at the time of your death? <i>If so, please explain below.</i>		
Are there any other charitable organizations you wish to make provisions for at the time of your death? <i>If so, please explain below.</i>		
Are you (or your spouse) currently the beneficiary of anyone else's trust? <i>If so, please explain below.</i>		
Do any of your children have special educational, medical, or physical needs?		
Do any of your children receive governmental support or benefits?		
Do you provide primary or other major financial support to adult children or others?		

PROPERTY INFORMATION

INSTRUCTIONS FOR COMPLETING THE *PROPERTY INFORMATION CHECKLIST*

General Headings

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 on this checklist. If so, use **extra sheets** of paper to list your additional property.

Type

Immediately after the heading for each kind of property is a brief explanation of what property you should list under that heading.

“Owner” of Property

How you own your property is **extremely important** for purposes of properly designing and implementing your estate plan. For each property please indicate how the property is titled. When doing so, please use the following abbreviations:

Owner of Property	Use
If married, Husband’s name alone, with no other person	H
If married, Wife’s name alone, with no other person	W
If married, Community Property with spouse	C
If married, joint tenancy if property outside Louisiana	JT
If you cannot determine how the property is owned	?

REAL PROPERTY

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

General Description and/or Address	Owner	Market Value	Loan Balance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
	<i>Total</i>	_____	_____

FURNITURE AND PERSONAL EFFECTS

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
<u>Miscellaneous Furniture and Household Effects (Total)</u>	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	<i>Total</i>	_____

AUTOMOBILES, BOATS AND RVS

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

Year/ Make/ Model	Owner	Market Value	Loan Balance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
	<i>Total</i>	_____	_____

BANK & SAVINGS ACCOUNTS

TYPE: Checking Account "CA", Savings Account "SA", Certificates of Deposit "CD", Money Market "MM" (indicate type below). Do not include IRA's or 401(k)'s here

Name of Institution and account number	Type	Owner	Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<i>Total</i>			_____

Note: If Account is in your name (or your spouse's name) for the benefit of a minor, please specify and give minor's name.

STOCKS AND BONDS

TYPE: List any and all stocks and bonds you own. If held in a brokerage account, lump them together under each account. (indicate type below)

Stocks, Bonds or Investment Accounts	Type	Acct. Number	Owner	Amount
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<i>Total</i>				_____

LIFE INSURANCE POLICES AND ANNUITIES

TYPE: Term, whole life, split dollar, group life, annuity. **ADDITIONAL INFORMATION:** Insurance company name, whether Life Insurance or Annuity, face/death benefit amount (if policy is whole life, provide cash surrender value), whose life is insured, who owns the policy, the current beneficiaries, who pays the premium, and who is the life insurance agent. *[If more space needed, attach separate page]*

<i>Total</i>

RETIREMENT PLANS

TYPE: Pension (P), Profit Sharing (PS), H.R. 10, IRA, SEP, 401(K). **ADDITIONAL INFORMATION:** Describe the type of plan, the plan name, the current value of the plan, and any other pertinent information.

Total _____

BUSINESS INTERESTS

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

Total _____

MONEY OWED TO YOU

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

Name of Debtor	Date of Note	Maturity Date	Owed to	Current Balance
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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.

Type	Owner	Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
<i>Total</i>		_____

Burial Plot – Client Yes No

Burial Plot – Spouse Yes No

Funeral Paid – Client Yes No

Funeral Paid – Spouse Yes No

DEBTS

Type	Owner	Balance Owed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
<i>Total</i>		_____

SUMMARY OF VALUES

ASSETS	Amount*		Total Value
	Husband	Wife	
Real Property			
Furniture and Personal Effects			
Automobiles, Boats and RV's			
Bank and Savings Accounts			
Stocks and Bonds			
Life Insurance and Annuities			
Retirement Plans			
Business Interests			
Money owed to you			
Anticipated Inheritance, Etc.			
Other Assets			
Total Assets:			
Total Debts:			

* *Joint Property values enter 1/2 in husband's column and 1/2 in wife's column.*

DESIGN INFORMATION

We will discuss this with you at the initial consultation but you should consider the persons you would want to act for you if you are unable to do so

PERSONS TO ACT FOR YOU:

GUARDIAN FOR MINOR CHILDREN: If you have any children under the age of 18, list in order of preference who you wish to be guardian.

Name and Address

Relationship

POWER OF ATTORNEY: If you were unable to make financial decisions for yourself, who would you want to make those decisions for you?

HUSBAND'S AGENT

Name

Relationship

Instructions or Guidelines

WIFE'S AGENT

Name

Relationship

Instructions or Guidelines

HEALTH CARE: If you were unable to make decisions for yourself, who would you want to make decisions for you with regard to your medical treatment?

HUSBAND'S AGENT

Name

Relationship

Instructions or Guidelines

WIFE'S AGENT

Name

Relationship

Instructions or Guidelines

Do you want to authorize your Medical Agent to take whatever steps are necessary to keep you in a personal residence rather than nursing home? Husband: Yes No Wife: Yes No

Do you want to provide that upon certification by 2 physicians of need for psychological or substance treatment, Agent may arrange for voluntary admission? Husband: Yes No Wife: Yes No

Husband's Physician's Name _____

Address _____

Phone _____

Wife's Physician's Name _____

Address _____

Phone _____

LIVING WILL: Do you want to provide that the moment of your death not be unnecessarily prolonged by artificial means or measures? _____

Do you want to provide that your organs and tissues should be made available for transplant purposes? _____

***This section should be completed only for
VA or Medicaid Benefits**

LONG TERM CARE PLANNING

HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

B. Spouse

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: [] Yes [] No

Spouse: [] Yes [] No

If yes, please explain:

B. OTHER ISSUES

	<u>Client</u>	<u>Spouse</u>
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 8. PHYSICIAN INFORMATION

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

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

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 12. 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 13. INCOME

In completing the following section, use the “name on the check” rule; that is, the person whose name appears on the payment vehicle 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. _____:	\$ _____	\$ _____	\$ _____

C. TOTALS (A thru B): \$ _____ \$ _____ \$ _____

PEOPLE PROVIDING ASSISTANCE

Who now has “assistance” responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

A. Responsible for Client:

- 1. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
- 2. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
- 3. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)

B. Responsible for Spouse:

- 1. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
- 2. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
- 3. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)

UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*:	\$ _____	\$ _____	\$ _____

2. If home is rented, total rent, including maint. fees, if any: \$ _____ \$ _____ \$ _____

* Is the senior citizen real property tax exemption being used? [] Yes [] No
 Is the veterans real property tax exemption being used? [] Yes [] No

B. 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 (ESTIMATED PER MONTH)

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

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Food:	\$ _____	\$ _____	\$ _____
2. Entertainment and travel:	\$ _____	\$ _____	\$ _____
3. Support for children:	\$ _____	\$ _____	\$ _____
4. _____ : (specify)	\$ _____	\$ _____	\$ _____
5. _____ : (specify)	\$ _____	\$ _____	\$ _____

E. TOTALS (A thru D): \$ _____ \$ _____ \$ _____

HEALTH AND LTC INSURANCE

If the person needing care 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>
<u>Acme Insurance</u> (sample)	<u>123-45-6789</u>	<u>Long-term care</u>	<u>\$ 3,000</u>	<u>\$ 300.00 per day</u>
_____	_____	_____	<u>\$</u>	<u>\$</u>
_____	_____	_____	<u>\$</u>	<u>\$</u>
_____	_____	_____	<u>\$</u>	<u>\$</u>
_____	_____	_____	<u>\$</u>	<u>\$</u>

PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	<u>Client</u>	<u>Spouse</u>
Will:	[] Yes [] No	[] Yes [] No
Revocable Living Trust:	[] Yes [] No	[] Yes [] No
Pour-Over Will:	[] Yes [] No	[] Yes [] No
General Durable Power of Attorney:	[] Yes [] No	[] Yes [] No
Health Care Power of Attorney (or Proxy):	[] Yes [] No	[] Yes [] No
Living Will:	[] Yes [] No	[] Yes [] No
_____ (specify):	[] Yes [] No	[] Yes [] No
_____ (specify):	[] Yes [] No	[] Yes [] No
_____ (specify):	[] Yes [] No	[] Yes [] No

TRANSFERS WITHIN 60 MONTHS

Has the person needing care transferred property to someone other than his or her spouse within the past 60 months? 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. _____	<u>\$</u> _____	_____
2. _____	<u>\$</u> _____	_____

3. _____ \$ _____

4. _____ \$ _____

B. Spouse

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

TRANSFERS TO OR FROM TRUSTS

Has the person needing care transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? 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. _____	\$ _____	_____

