TURNING POINT LEGAL, PC

Laura D. Givens
laura@tpl.legal

Norma M. Wells
norma@tpl.legal

1640 Blount Avenue
Guntersville, Alabama 35976

www.TurningPointLegalPC.com

Voice: (256) 486-3407
Facsimile: (256) 486-3409

CLIENT INFORMATION WORKSHEET

Case/Matter (check all that apply)

_____ Elder Law (Asset Protection) Planning
_____ Medicaid / Nursing Home Planning
_____ Estate Planning
_____ Special Needs Planning
_____ Guardianship/Conservatorship
_____ Estate or Trust Administration
_____ Family Law / Divorce
_____ Real Estate

A. PERSONAL DATA

Date Completed _____

Name _____ Spouse's Name _____

Address _____

County of residence _____ Preferred phone number(s) _____

Date of Birth _____ Spouse's Date of Birth _____

Social Security Number _____ Spouse's Social Security Number _____

Date of Marriage (if applicable) _____

Email Address _____

Workplace/Occupation _____ Work Phone: _____

Client's Agent or Designated Contact Person (if any)

Name _____ Relationship to Client(s) _____

Address _____

Preferred phone number _____ Email Address _____

B. REFERRAL

By whom were you referred? ______________________________________

How did you hear about our firm? (Google, Facebook, Other) _______________________

C. CHILDREN

- **Name** ________________________ Gender ___ Date of Birth _____ Marital Status _______

  Child of both clients? _________ If not, whose child? _________ Legally adopted? ____

  Address ____

  Phone Number _______________________

- **Name** ________________________ Gender ___ Date of Birth _____ Marital Status _______

  Child of both clients? _________ If not, whose child? _________ Legally adopted? ____

  Address ____

  Phone Number ____________________

- **Name** ________________________ Gender ___ Date of Birth _____ Marital Status _______

  Child of both clients? _________ If not, whose child? _________ Legally adopted? ____

  Address ____

  Phone Number ____________________

- **Name** ________________________ Gender ___ Date of Birth _____ Marital Status _______

  Child of both clients? _________ If not, whose child? _________ Legally adopted? ____

  Address ____

  Phone Number ____________________

1. **Are all of the children in good health? Yes ___ No ___**
2. **Are any of the children blind or disabled? Yes ___ No ___**
3. **Do any of the children receive SSI or other government assistance?**

   Yes ___ No ___

D. GRANDCHILDREN / OTHER DEPENDENTS / BENEFICIARIES

- **Name** _____ Gender ___ Date of Birth _____ Marital Status _____

  Address _____

- **Name** _____ Gender ___ Date of Birth _____ Marital Status _____

  Address _____

- **Name** _____ Gender ___ Date of Birth _____ Marital Status _____

  Address _____

- **Name** _____ Gender ___ Date of Birth _____ Marital Status _____

  Address _____

4. **Are all named in good health?** **Yes ____ No ____**
5. **Are any blind or disabled?** **Yes ____ No ____**
6. **Do any receive SSI or other government assistance?** **Yes ____ No ____**

If you are seeking assistance regarding Elder Law (Asset Protection) Planning, Estate Planning, or Nursing Home Placement / Medicaid Planning please complete Sections E, F, G, and H below. Otherwise skip to Certification.

E. VETERAN SERVICE INFORMATION

Are you or your spouse a veteran? **Yes ____ No ____**

Did the veteran serve during one of the following war-times: **Yes ____ No ____**

WWII 12/07/1941 – 12/31/1946 Korean War 06/27/1950 – 01/31/1955

Vietnam Conflict 08/05/1964 – 05/07/1975 Gulf War 08/02/1990 - Present

If yes, what branch of service, for how long, and what type of discharge did the veteran receive:

Branch: _____ Length of Service: _____ Type of Discharge: _____

F. ASSETS

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Husband	Wife	Joint	Liabilities
AUTOMOBILE				
ADDITIONAL AUTOMOBILE				
RECREATIONAL VEHICLES, BOATS, OR FARM EQUIPMENT				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICIATES OF DEPOSIT				
RESIDENCE				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
IRA				
OTHER REAL ESTATE				
CARE FACILITY DEPOSIT				
RETIREMENT ACCOUNTS OR 401(K)				
OTHER				
TOTALS				

Do you have a Safe Deposit Box? Yes ____ No ____ If yes, where? _____ Box #:_____

G. LIFE INSURANCE

COMPANY NAME (include address and policy No.)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

***It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.**

H. GIFTS

Please list gifts made in excess of $100.00 in any one month, to an individual or group of individuals, within the past 60 months:

Recipient _____ Maker _____

Date _____ Amount _____

Recipient _____ Maker _____

Date _____ Amount _____

Recipient _____ Maker _____

Date _____ Amount _____

Recipient _____ Maker _____

Date _____ Amount _____

I. DISPOSITION INTENTIONS

1. Spouse, Children and Others

Do you wish to provide first for your spouse and secondarily for your children? Yes ___ No ___

Do you wish to treat all of your children equally? Yes _____ No _____

After your spouse's death, at what or ages do you want distribution(s) to your children? _____

Do you want to leave a specific amount of money or a percentage of your estate to your grandchildren or another beneficiary? Yes ___ No ___ To who and at what age? _____

J. WILL NOMINATIONS (Select in order of preference who you wish to serve in the following capacities. Select Guardians only if you have minor children.)

1. Personal Representatives

Name _____ Phone Number _____

Address _____ _____

First Alternate - Name _____ Phone Number _____

Address _____ _____

Second Alternate- Name _____ Phone Number _____

Address _____ _____

2. Trustee (if any)

Name _____ Phone Number _____

Address _____ _____

First Alternate - Name _____ Phone Number _____

Address _____ _____

Second Alternate- Name _____ Phone Number _____

Address _____ _____

3. **Guardian (if any)**

Name _____ Phone Number _____

First Alternate - Name _____ Phone Number _____

4. **Same appointments for spouse?** Yes _____ No _____ (if no, please list appointments on back of this page).

K. POWER OF ATTORNEY NOMINATIONS (Select in order of preference who you wish to serve as your Agent.)

Name _____ Phone Number _____

Address _____ _____

First Alternate - Name _____ Phone Number _____

Address _____ _____

Second Alternate - Name _____ Phone Number _____

Address _____ _____

L. HEALTH CARE PROXY NOMINATIONS (Select in order of preference who you wish to serve as your Health Care Proxy to make decisions for you when you are unable to communicate your wishes.)

Name _____ Phone Number _____

Address _____ _____

First Alternate - Name _____ Phone Number _____

Address _____ _____

Second Alternate- Name _____ Phone Number _____

Address _____ _____

M. CURRENT HEALTH/ HOUSE SITUATION (If you are seeking assistance with Nursing Home Placement or Medicaid Application, please complete the following):

Is the person alive? (If deceased, the following questions may be disregarded.)
Yes _____ No _____

Does the person need any assistance with the following (check all that apply):
____ Eating ____ Bathing _____ Dressing _____ Toileting _____ Transferring

Does the person suffer from a mental disability (i.e. Alzheimer's)? Yes _____ No _____

Does the person still operate a motor vehicle? Yes _____ No _____

Does the person live alone, without any assistance? Yes _____ No _____

Does the person currently reside in an assisted living facility? Yes _____ No _____

Does the person currently reside in a nursing facility? Yes _____ No _____

Is the person receiving care through a caregiver agreement? Yes _____ No _____

N. CURRENT HEALTH / HOUSING INFORMATION – SPOUSE

Is the spouse alive? (If deceased, the following questions may be disregarded.)
Yes _____ No _____

Does the spouse need any assistance with the following (check all that apply):
□ Eating □ Bathing □ Dressing □ Toileting □ Transferring

Does the spouse suffer from a mental disability (i.e. Alzheimer's)? Yes _____ No _____

Does the spouse still operate a motor vehicle? Yes _____ No _____

Does the spouse live alone, without any assistance? Yes _____ No _____

Does the spouse currently reside in an assisted living facility? Yes _____ No _____

Does the spouse currently reside in a nursing facility? Yes _____ No _____

Is the spouse receiving care through a caregiver agreement? Yes _____ No _____

CERTIFICATION

The undersigned hereby represents to Turning Point Legal, PC that information contained in this intake form is accurate and complete, and that the undersigned understands that Turning Point Legal, PC will rely on this information for planning purposes. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct and negative impact on Medicaid and/or VA eligibility.

Dated: _____

Signature of Client or Client Representative: _____