



Confidential
Discovery Planning
Workbook
(for Married Persons)

Instructions:

This workbook must be returned to our office along with your supporting documents in the blue folder at least 3 days before the day of your appointment.

If you need assistance completing this information please call for assistance at (231) 799-4993 and we will help you.

Don't worry about total accuracy. Just do the best you can!
We look forward to seeing you soon.

Phone (231) 799-4993 • Fax (231) 798-9000 • Toll Free (888) 807-1212
800 Ellis Road • Suite 172 • Muskegon, Michigan 49441
www.MedicaidResources.com • help@medicaidresources.com

Date Prepared:
Who referred you to our office:

My Personal Information:

Full Legal Name:		
Name Used to Sign Legal Documents:		
I prefer to be called:		
Address:		
City:	State:	Zip:
Home Telephone:	Mobile Phone:	Fax:
Email Address:		Social Security #:
Date of Birth:	Age:	Place of Birth:
Citizenship:		

My Employment Information:

Employer:	Occupation:	
Business Address:		
City:	State:	Zip:
Business Phone:	Fax:	Email:

My Relationship History:

Are you married? Yes or No	If Yes, please complete the information on the next page.	
Date of Marriage to present spouse:		
Do you have a Marital Agreement regarding your assets? Yes or No		
Are you widowed? Yes or No	Deceased Spouse's Name:	Date of Death:

Are you divorced? Yes or No	Former Spouse's Name:	Date of Divorce Judgment:
Do you have any unresolved child or spousal support obligations? Yes or No	Describe:	

My Spouse's Personal Information:

Full Legal Name:		
Name Used to Sign Legal Documents:		
I prefer to be called:		
Address:		
City:	State:	Zip:
Home Telephone:	Mobile Phone:	Fax:
Email Address:		Social Security #:
Date of Birth:	Age:	Place of Birth:
Citizenship:		

My Spouse's Employment Information:

Employer:	Occupation:	
Business Address:		
City:	State:	Zip:
Business Phone:	Fax:	Email:

My Spouse's Relationship History:

Have you been married before? Yes or No		
Are you widowed? Yes or No	Deceased Spouse's Name:	Date of Death:

Are you divorced? Yes or No	Former Spouse's Name:	Date of Divorce Judgment:
Do you have any unresolved child or spousal support obligations? Yes or No	Describe:	

Our Planning History:

Have you or your spouse previously completed a will or living trust? Yes or No	
<i>If Yes, please bring copies of your wills, trust agreements, powers of attorney, living wills, health care decision-making documents or any other estate planning documents to your initial interview.</i>	
If Yes, what is the date of your will or living trust?	
Who drafted your will or living trust?	
Where is your original will filed?	
Do you have a General Durable Power of Attorney? Yes or No	Date:
Do you have a General Durable Power of Attorney for Health Care or other Advance Directive? Yes or No	Date:

Our Planning Goals:

*Lowest to Highest
(circle one)*

Avoiding Probate	1 2 3 4 5 6 7 8 9 10
Reducing Estate Taxes	1 2 3 4 5 6 7 8 9 10
Reducing Income Taxes	1 2 3 4 5 6 7 8 9 10
Maximizing My Investments	1 2 3 4 5 6 7 8 9 10
Consolidating My Resources	1 2 3 4 5 6 7 8 9 10
Having Enough Income	1 2 3 4 5 6 7 8 9 10
Protection from Nursing Home Expenses	1 2 3 4 5 6 7 8 9 10
Charitable Planning	1 2 3 4 5 6 7 8 9 10
Protecting a Special Needs Child	1 2 3 4 5 6 7 8 9 10

Information About Our Children:

Please provide us with the following information regarding your children. Under "comments" please describe your relationship with this child, his or her spouse or partner, and grandchildren. Do you have any specific wishes with respect to their inheritance?

Please indicate whether the child is from Husband, Wife or Both Spouses (H=Husband; W=Wife; or, B=Both).

Child #1:

Full Legal Name:		Child or Beneficiary of: <i>H or W or B</i>	
Address:			
City:		State:	Zip:
Home Telephone:	Mobile Phone:		Fax:
Email Address:			Social Security #:
Date of Birth:	Age:		Place of Birth:
Occupation:		Education:	
Spouse Name:			
Children's Names and Birthdates:			
Comments:			

Child #2:

Full Legal Name:		Child or Beneficiary of: <i>H or W or B</i>	
Address:			
City:		State:	Zip:
Home Telephone:	Mobile Phone:		Fax:
Email Address:			Social Security #:
Date of Birth:	Age:		Place of Birth:
Occupation:		Education:	
Spouse Name:			

Children's Names and Birthdates:
Comments:

Child #3:

Full Legal Name:	Child or Beneficiary of: <i>H or W or B</i>	
Address:		
City:	State:	Zip:
Home Telephone:	Mobile Phone:	Fax:
Email Address:		Social Security #:
Date of Birth:	Age:	Place of Birth:
Occupation:	Education:	
Spouse Name:		
Children's Names and Birthdates:		
Comments:		

Child #4:

Full Legal Name:	Child or Beneficiary of: <i>H or W or B</i>	
Address:		
City:	State:	Zip:
Home Telephone:	Mobile Phone:	Fax:
Email Address:		Social Security #:
Date of Birth:	Age:	Place of Birth:
Occupation:	Education:	

Spouse Name:	
Children's Names and Birthdates:	
Comments:	

Child #5:

Full Legal Name:		Child or Beneficiary of: <i>H or W or B</i>	
Address:			
City:		State:	Zip:
Home Telephone:	Mobile Phone:		Fax:
Email Address:		Social Security #:	
Date of Birth:	Age:	Place of Birth:	
Occupation:		Education:	
Spouse Name:			
Children's Names and Birthdates:			
Comments:			

Please use additional pages if you have more than 5 living children.

Do you have any deceased children who left children of their own?	Yes or No
Name:	Date of Death:
Name:	Date of Death:

Other Dependents:

Do you or your spouse have anyone who depends on either of you for all or part of their support?	Yes or No
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Questions About Our Children or Other Dependents:

(Circle YES or NO)

1. Do any of your children or beneficiaries receive governmental support or benefits because of a disability or handicap?	Yes or No
2. Do any of your children or beneficiaries have special educational, medical, or physical needs?	Yes or No
3. Are any of your children or beneficiaries institutionalized?	Yes or No
<i>If you answered YES to any of the above questions, please describe the type of disability that your child or beneficiary has:</i>	
4. Do any of your children or beneficiaries have any other special needs or circumstances that are concerns for you?	Yes or No
<i>Comments:</i>	

Our Medical Care Instructions:

What is your definition of disability?	
Do you or your spouse have any health concerns?	Yes or No
If Yes, please describe your concerns:	
Do you have any special requests for how or when you want your assets sold to pay for your care <i>(for example, you may want certain assets liquidated before others)</i> ?	Yes or No
If Yes, please describe your preferences:	
Do you have long term care insurance that will pay for your care at home or in an institution?	Yes or No
If Yes, please tell us about your long term care insurance:	
Have you ever applied for or been denied coverage for long term care insurance?	Yes or No
Do either of you have any special requests about the quality of medical care you receive?	Yes or No
If Yes, please describe your preferences:	

Instructions About Life Sustaining Treatment:

If you are in a coma or a persistent vegetative state, do you wish to receive artificial delivery of food, water or other forms of artificial life support?	Yes or No
If you are terminally ill and no longer able to participate in your medical treatment decisions, do you wish to receive artificial delivery of food, water or other forms of artificial life support if it would only delay your inevitable death?	Yes or No

<p>If there are any circumstances where a reasonable person would conclude that the burden of continuing care or treatment is greater than the benefit received, do you wish to receive artificial delivery of food, water or other forms of artificial life support?</p>	<p><i>Yes or No</i></p>
<p><i>Additional comments about life sustaining treatment:</i></p>	

My Physician:

Name:
Address:
City, State, & Zip:
Phone:

My Spouse's Physician:

Name:
Address:
City, State, & Zip:
Phone:

Final Arrangements:

Do you own a cemetery plot?		<p><i>Yes or No</i></p>
If yes, where is it located:	Cemetery Name:	Plot Number:
Have you made any other prearrangements for funeral or burial?		<p><i>Yes or No</i></p>
If Yes, please describe what arrangements you have made:		
If No, do you have any particular preferences regarding the choice of funeral home, form of burial or cremation?		

Military Service:

Are you or your spouse a veteran of the U.S. Armed Forces?	<i>Yes or No</i>
If yes, please state your branch and dates of service:	
Are you or your spouse a disabled veteran?	<i>Yes or No</i>

Religious Affiliation:

Who is your pastor, priest, rabbi or spiritual advisor, if any?
What is the name of your church, parish or synagogue, if any?

Lifetime Gifting Considerations:

Are you currently making annual gifts to any person or charity?	<i>Yes or No</i>	
If Yes, please describe:		
Have you or your spouse made any large gifts to any person or charity in any one year?	<i>Yes or No</i>	
If Yes, please describe the gifts you have made below <i>(please provide us with a copy of any gift taxes returns you have filed, if any)</i> :		
Gift to:	Gift Amount:	Gift Date:
Gift to:	Gift Amount:	Gift Date:
Gift to:	Gift Amount:	Gift Date:
Gift to:	Gift Amount:	Gift Date:

Our Financial Decision Makers:

My Financial Decision Maker:

Name:
Address:
City, State, & Zip:
Phone:

My Spouse's Financial Decision Maker:

Name:
Address:
City, State, & Zip:
Phone:

My Alternate:

Name:
Address:
City, State, & Zip:
Phone:

My Spouse's Alternate:

Name:
Address:
City, State, & Zip:
Phone:

Medical Decision Makers:

My Medical Decision Maker:

Name:
Address:
City, State, & Zip:
Phone:

My Spouse's Medical Decision Maker:

Name:
Address:
City, State, & Zip:
Phone:

My Alternate:

Name:
Address:
City, State, & Zip:
Phone:

My Spouse's Alternate:

Name:
Address:
City, State, & Zip:
Phone:

Our Assets:

1. **CASH ACCOUNTS.** List your checking and savings accounts and certificates of deposit below. Do not include IRAs here. Bring a recent bank statement for each.

	<i>Owner:</i>	<i>Institution:</i>	<i>Account #:</i>	<i>Type:</i>	<i>Value:</i>

OFFICE USE

Joint	Husband	Wife	HRLT	WRLT	Other

2. **INVESTMENT ACCOUNTS AND MUTUAL FUNDS.** Includes stock holdings managed by brokerage firms. List your investment accounts below. Do not include tax deferred accounts, such as IRAs, etc. here. Bring a recent statement for each account.

	<i>Owner:</i>	<i>Institution:</i>	<i>Account #:</i>	<i>Type:</i>	<i>Value:</i>

OFFICE USE

Joint	Husband	Wife	HRLT	WRLT	Other

3. **STOCK CERTIFICATES.** List all your stocks managed by the company (not a broker) or evidenced by certificate. Bring the certificates or book entry statements for each. Indicate if any were received through a stock option plan, and the date the option was exercised, if applicable.

	<i>Owner</i>	<i>Company</i>	<i>Certificate #:</i>	<i>No. of Shares:</i>	<i>Value:</i>

OFFICE USE

Joint	Husband	Wife	HRLT	WRLT	Other

4. **BOND CERTIFICATES.** List all bonds evidenced by certificate. Bring the certificates or book entry statements for each.

	<i>Owner:</i>	<i>Company:</i>	<i>Account or Certificate #:</i>	<i>Shares:</i>	<i>Value:</i>

OFFICE USE

Joint	Husband	Wife	HRLT	WRLT	Other

5. **PERSONAL EFFECTS.** Includes vehicles, boats, RVs, etc. Also list any other items which may be more valuable than ordinary household belongings such as artwork, jewelry, antiques, etc.

	<i>Owner</i>	<i>Description of Item</i>	<i>Appraised? Yes or No</i>	<i>Value</i>

OFFICE USE

Joint	Husband	Wife	HRLT	WRLT	Other

6. **QUALIFIED RETIREMENT PLANS.** Includes IRAs, 401Ks, IRA Annuities, 403b, etc. List here the accounts funded by money included in taxable income on your income tax return (including IRA-type annuities). Bring a recent statement for each account.

	<i>Owner:</i>	<i>Institution:</i>	<i>Account #:</i>	<i>Type:</i>	<i>Value:</i>

OFFICE USE

Joint	Husband AGE:	Wife AGE:	HRLT	WRLT	Other

7. **LIFE INSURANCE POLICIES.** Bring a recent policy report, policy, statement or current in force illustration for each policy.

	<i>Owner/ Insured:</i>	<i>Company:</i>	<i>Policy #:</i>	<i>Type:</i>	<i>Face Value</i>	<i>Cash Surrender Value</i>	<i>Death Benefit</i>

OFFICE USE

Joint	Husband	Wife	HRLT	WRLT	Other

8. **NON-QUALIFIED ANNUITIES.** Include annuities funded by money included in taxable income on your income tax return. Bring a recent policy report, policy, or statement for each.

	<i>Owner/ Insured:</i>	<i>Company:</i>	<i>Policy #:</i>	<i>Type:</i>	<i>Face Value</i>	<i>Cash Surrender Value</i>	<i>Death Benefit</i>

12. **OTHER ASSETS.** Including any other assets not included above.

	<i>Owner</i>	<i>Description</i>	<i>Value</i>

OFFICE USE

Joint	Husband	Wife	HRLT	WRLT	Other

Our Liabilities:

	JOINT	Husband	Wife
Loans Payable			
Accounts Payable			
Real Estate Mortgage – Residence			
Real Estate Mortgage			
Loans against life insurance			
Other obligations			
Car Loans			
Credit Cards			
TOTAL LIABILITIES			

Our Income:

SOURCE

DOLLAR AMOUNTS

	JOINT	Husband	Wife
Salary and Wages			
Investment Income and Dividends			
Social Security			
Pension or Retirement Plans			
IRA/401k			
Rental Income			
Other			
TOTAL INCOME			

Our Health Insurance Premium Expenses:

	JOINT	Husband	Wife
Medicare			
Medicare Supplement			
Medicare Part D (Prescription)			
Health Insurance			
Dental Insurance			
Vision Insurance			
Long Term Care Insurance			
Other			
TOTAL MONTHLY PREMIUM EXPENSES			

Our Household Expenses:

	JOINT	Husband	Wife
Mortgage Payment			
Rent			
Association Dues			
Real Estate Taxes or Assessments			
Homeowner or Renter Insurance			
Electric			
Gas			
Phone			
Cable			
Other			
TOTAL MONTHLY EXPENSES			

Summary Page:

ASSETS	HELD AS			TRANSFER TO		
	J	H	W	HRLT	WRLT	Other
1. Cash Accounts						
2. Investment Accounts						
3. Stocks						
4. Bonds						
5. Personal Effects						
6. Retirement Plans						
7. Life Insurance						
8. Annuities						
9. Land Contracts/Notes/ Receivables						
10. Business Interests						
11. Real Estate						
12. Other Assets -						
TOTAL ASSETS						
(TOTAL LIABILITIES)						
NET ESTATE						