FENDRICK MORGAN

LIFE REQUIRES PLANNING WORKBOOK
(SINGLE)

Please complete this Workbook to the best of your ability. Your answers to the questions asked herein will allow us to provide you with the most appropriate counsel and care. If you have a question about any of the information requested, or are unsure how to answer any question asked herein, please leave it blank and we can review it with you at your appointment.

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A. ***PERSONAL INFORMATION***

Nickname: ______________________

Full Name____
(print name as shown on your checks and other financial accounts)

E-mail Address____

Cell Number______________________________Home Number_________________________________

Street Address____

City____ State___________ Zip______

Birth Date____________________________________Social Security No.________________________

U.S. Citizen? Yes G No G Veteran? Yes G No G

If widowed, please list name of spouse and date of death ____

Was your former spouse a Veteran? Yes □ No □

If you are a Veteran, are you receiving Tri-Care? Yes □ No □

Do you have long term care insurance? Yes □ No □

B. ***MEDICAL DATA***

1. HEALTH

Have you had any medical diagnoses of which we should be aware in our representation of you? If so, please describe your diagnosis and prognosis: ____

____

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Have you been diagnosed with any chronic condition (such as dementia of any kind, Alzheimer's disease, Parkinson's Disease, Multiple Sclerosis, etc.)? If so, please explain: ________________________________

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Have you noticed any recent change in your memory, appetite, energy levels, balance, or anything else, which might affect your activities of daily life?

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Do you require any assistance with activities of daily living (such as administering medications, driving, cooking, grooming, feeding, transportation, etc.)? If so, please explain:

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2. MEDICAL INSURANCE

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior Gold? Yes □ No □

If you are a Pennsylvania resident, are you currently receiving benefits under PACE or PACE NET?
Yes □ No □

If you are a Veteran, are you currently receiving prescription benefits from the Veteran's Administration?
Yes □ No □

Do you maintain any have any medical, prescription, or dental insurance other than Medicare? Yes □ No □
If yes, please provide carrier information, who is covered and any premiums paid:

____

____

C. *FAMILY*

1. CHILDREN (if applicable)

Child's Name	Address (including zip code)	Date of Birth

Are all of your children in good health? Yes □ No □

Are any of your children blind or disabled? Yes □ No □

Are any of your children receiving SSI or other form of government entitlement? Yes □ No □

If yes, how much is the child's monthly payment? $___________________________

Child is receiving: Medicaid □ Medicare □ Veterans Disability Benefit □

Do any of your family members have any problems with:

Drug Addiction?	Yes □	No □
Alcoholism?	Yes □	No □
Spendthrift?	Yes □	No □
Marital Difficulty?	Yes □	No □
Financial Difficulty?	Yes □	No □

Do any of your children live with you in your home? Yes □ No □

If so, who and for how long?____

2. GRANDCHILDREN

Grandchild's Name	Address (including zip code)	Date of Birth

Do you wish to treat all of your grandchildren equally? Yes □ No □

If not, why? ____

Do you want to leave your grandchildren a specific bequest or percentage distribution? Yes □ No □
If so, how much do you want to leave your grandchildren? ______________________

Are any of your grandchildren disabled? Yes □ No □

Are any of your grandchildren receiving SSI or other form of government entitlement? Yes □ No □

Grandchild is receiving: Medicaid □ Medicare □ Veterans Disability Benefit □

At what age do you want distributions to your grandchildren? ______________________

(You might decide to distribute funds to adult grandchildren immediately or you may decide to hold the assets in trust for your grandchildren until they reach certain ages. For example, you may want your grandchildren to receive 1/3 of their share at age 25, 1/2 of the remaining amount at age 30 and the entire remaining amount at age 35, or any other age/ages that make sense to you.)

3. OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than children, grandchildren, i.e., charity or other person?
Yes □ No □

If yes, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

D. *MONTHLY INCOME*

In completing this section, please provide only your fixed monthly income amounts. For example, if you receive periodic dividend payments or required minimum distributions from an IRA, you do not need to list that income here. We are interested in your fixed, recurring monthly income.

Monthly Income

Gross Social Security Benefits
(*include $134.00 Medicare Part B Deduction, if applicable*) $_______________

Gross Monthly Pension
(*Do not reduce this amount by any monies taken out for federal income taxes, health insurance, or any other reason*.) $_______________

VA Disability Benefit $_______________

Annuity Income $_______________

Rental Income $_______________

TOTAL MONTHLY INCOME $_______________

E. ***FINANCIAL SUMMARY*** *- Please bring spreadsheet of your financial assets or fill out the information requested below and bring most recent statements, if possible.*

	ASSETS	**LIABILITIES**
Bank Accounts	$_________	$_________
Real Estate (residence) *[bring copy of deed, if possible]*	$_________	$_________
Real Estate (other) *[bring copies of all deeds, if possible]*	$_________	$_________
Non-Retirement Investments (*Brokerage Accounts, Stock, Mutual Fund, CDs, etc.*)	$_________	$_________
	$_________	$_________
	$_________	$_________
	$_________	$_________
Non-Retirement Account Annuities	$_________	$_________
	$_________	$_________
	$_________	$_________
	$_________	$_________
Retirement Account Assets *(IRAs, 401(k), 403(b), etc.)*	$_________	$_________
	$_________	$_________
Business Interests *[if any]*	$_________	$_________
Anticipated Inheritance *[if any]*	$_________	$_________
Life Insurance	$_________	$_________
TOTALS	$_________	$_________

Personal Residence:

Tax Block #____________________, Lot #__________________ (Can be obtained from Tax Bill)

Addresses of real property other than personal residence:

(1) Street____________________________________City_______________State__________Zip_______
Tax Block #____________________, Lot #__________________ (Can be obtained from Tax Bill)

(2) Street____________________________________City_______________State__________Zip_______
Tax Block #____________________, Lot #__________________ (Can be obtained from Tax Bill)

F. ***LAST WILL AND TESTAMENT***

DISPOSITIVE INTENTIONS -CHILDREN

Do you wish to provide primarily for your children? Yes □ No □

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

If not, why? ____

EXECUTOR

Whom do you want to serve as your Executor?

First Choice: ____

Second Choice: ____

Third Choice ____

TRUSTEE

If a Trust is established whom do you want to serve as your Trustee?

First Choice ____

Second Choice ____

G. *POWER OF ATTORNEY*

Do you currently have a Power of Attorney? Yes □ No □

First Choice ____
(Name) (Address)

Second Choice ____
(Name) (Address)

H. *LIVING WILL*

Do you want a Living Will? Yes □ No □

Do you want your Living Will to provide for withdrawal of artificial food and fluid? Yes □ No □

Do you want to donate your eyes or organs? Yes □ No □

Whom do you want to make your medical decisions?

First Choice ____
(Name) (Address)

Second Choice ____
(Name) (Address)

Do you want the person making your medical decisions to consult with any other person prior to acting?
Yes □ No □

If yes, with whom? ____

I. *GIFTS*

Have you made gifts, to an individual or group of individuals, or to a trust within the past 60 months?
Yes □ No □

If yes, list below:

Recipient______________________________ Date ____________ Amount __________

Recipient______________________________ Date ____________ Amount __________

Recipient______________________________ Date ____________ Amount __________

Recipient______________________________ Date ____________ Amount

Have you ever filed a Federal Gift Tax Return? Yes □ No □

If so, please state details ____

J. LIFE INSURANCE

Name of Insurance Company________________________________ Policy # ______________________

Street Address____

City_____________________________________ State_____________________Zip_____________

Type of Policy____________________________Owner____________________________________

Insured__________________________________Beneficiary________________________________

Death Benefit: $___________________________Face Value: $__________Cash Value: $________

Name of Insurance Company________________________________Policy #_______________________

Street Address____

City_____________________________________State_____________________Zip_____________

Type of Policy____________________________Owner_____________________________________

Insured__________________________________Beneficiary_________________________________

Death Benefit: $___________________________Face Value: $____________Cash Value: $_______

Name of Insurance Company_________________________________Policy #______________________

Street Address____

City____________________________________State_________________ Zip _________________

Type of Policy___________________________Owner______________________________________

Insured_________________________________Beneficiary__________________________________

Death Benefit: $__________________________Face Value: $_____________Cash Value: $ ______

Name of Insurance Company_________________________________Policy #______________________

Street Address ____

City____________________________________State_________________ Zip _________________

Type of Policy___________________________Owner______________________________________

Death Benefit: $__________________________Face Value: $_____________Cash Value: $ ______

K. MISCELLANEOUS

Do you have any other legal issues, which I should be aware of? Yes □ No □

If yes, please explain ______________________________

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L. REFERRAL

By Whom Were You Referred To This Office? ______________________________

Name______________________________

Street Address ______________________________

City______________________________ State___________ Zip_____

Have you visited our website? Yes □ No □

M. *CERTIFICATION*

The undersigned hereby represents to Fendrick Morgan, LLC, that the information contained in this intake form is accurate and complete. The undersigned is aware that the law firm will rely on this information and further understands that the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

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