50 Quincy Avenue
Quincy, MA 02169

418 Massachusetts Ave
Arlington, MA 02476

10 Liberty St., Suite 215
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945 Concord St., Suite 131
Framingham, MA 01701

1436 Route 132
Hyannis, MA 02061

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CONFIDENTIAL PLANNING INTAKE FORM

This form is an important tool to evaluate your current planning or to develop an appropriate plan for you and your family. Your accuracy and completeness in responding will help us best evaluate and act on your behalf. **Bring this form with you to your appointment, completed to the best of your ability.**

Please list names as they would appear on legal documents, including all middle names and avoiding initials and/or nicknames.

Proposed Client	*Suffix* / *Last Name*	*First Name*	*Middle Name*	*Date of Birth*	
	Street Address	*City, State, ZIP code*		*Social Security Number*	
	Home Phone	*Business Phone*	*Cell Phone*	*Fax Number*	
	Email address	*Check all that apply: ☐ Blind ☐ Disabled ☐ Collecting SSI ☐ Other Government Subsidy:*			
	Occupation (or former, if retired)	*Retired* ☐ *Yes* ☐ *No*	*United States Citizen* ☐ *Yes* ☐ *No*	*US Veteran* ☐ *Yes: dates of service -* ☐	
Spouse	*Suffix* / *Last Name*	*First Name*	*Middle Name*	*Date of Birth*	
	Street Address	*City, State, ZIP code*		*Social Security Number*	
	Home Phone	*Business Phone*	*Cell Phone*	*Fax Number*	
	Email address	*Check all that apply: ☐ Blind ☐ Disabled ☐ Collecting SSI ☐ Other Government Subsidy:*			
	Occupation (or former, if retired)	*Retired* ☐ *Yes* ☐ *No*	*US Citizen* ☐ *Yes* ☐	*US Veteran* ☐ *Yes* *Dates of service:*	*Date of marriage* / *Date of Death (if applies)*
Contact Person (if other than client)	*Suffix* / *Last Name*	*First Name*	*Middle Name*	*Date of Birth*	
	Street Address	*City, State, ZIP code*		*Relationship*	
	Home Phone	*Business Phone*	*Cell Phone*	*Fax Number*	
	Email address	*Check all that apply: ☐ Blind ☐ Disabled ☐ Collecting SSI ☐ Other Government Subsidy:*			

Name of Person Filling Out this Form _____Relationship_____

How Did You Hear About Us?_____

Children ***(attach additional pages, if needed)***

Child 1	*Suffix* / *Last Name*	*First Name*	*Middle Name*	*Date of Birth*	
	Street Address	*City, State, ZIP code*	*Child of:* ☐ *Client* ☐ *Spouse* ☐ *Both*		
	Home Phone	*Business Phone*	*Cell Phone*	*Fax Number*	
	Email address	*Check all that apply:* ☐ *Disabled* ☐ *Receiving SSI* ☐ *Other Government Subsidy:* ☐ *Deceased; Date of Death:*			
		If Deceased, Please List Any Living Children			
Child 2	*Suffix* / *Last Name*	*First Name*	*Middle Name*	*Date of Birth*	
	Street Address	*City, State, ZIP code*	*Child of:* ☐ *Client* ☐ *Spouse* ☐ *Both*		
	Home Phone	*Business Phone*	*Cell Phone*	*Fax Number*	
	Email address	*Check all that apply:* ☐ *Disabled* ☐ *Receiving SSI* ☐ *Other Government Subsidy:* ☐ *Deceased; Date of Death:*			
		If Deceased, Please List Any Living Children			
Child 3	*Suffix* / *Last Name*	*First Name*	*Middle Name*	*Date of Birth*	
	Street Address	*City, State, ZIP code*	*Child of:* ☐ *Client* ☐ *Spouse* ☐ *Both*		
	Home Phone	*Business Phone*	*Cell Phone*	*Fax Number*	
	Email address	*Check all that apply:* ☐ *Disabled* ☐ *Receiving SSI* ☐ *Other Government Subsidy:* ☐ *Deceased; Date of Death:*			
		If Deceased, Please List Any Living Children			

Children ***(attach additional pages, if needed)***

Child 4	*Suffix*	*Last Name*	*First Name*	*Middle Name*	*Date of Birth*
	Street Address		*City, State, ZIP code*		*Child of:* ☐ *Client* ☐ *Spouse* ☐ *Both*
	Home Phone		*Business Phone*	*Cell Phone*	*Fax Number*
	Email address		*Check all that apply:* ☐ *Disabled* ☐ *Receiving SSI* ☐ *Other Government Subsidy:* ☐ *Deceased; Date of Death:*		
			If Deceased, Please List Any Living Children		
Child 5	*Suffix*	*Last Name*	*First Name*	*Middle Name*	*Date of Birth*
	Street Address		*City, State, ZIP code*		*Child of:* ☐ *Client* ☐ *Spouse* ☐ *Both*
	Home Phone		*Business Phone*	*Cell Phone*	*Fax Number*
	Email address		*Check all that apply:* ☐ *Disabled* ☐ *Receiving SSI* ☐ *Other Government Subsidy:* ☐ *Deceased; Date of Death:*		
			If Deceased, Please List Any Living Children		
Child 6	*Suffix*	*Last Name*	*First Name*	*Middle Name*	*Date of Birth*
	Street Address		*City, State, ZIP code*		*Child of:* □ *Client* □ *Spouse* □ *Both*
	Home Phone		*Business Phone*	*Cell Phone*	*Fax Number*
	Email address		*Check all that apply:* □ *Disabled* □ *Receiving SSI* □ *Other Government Subsidy:* □ *Deceased; Date of Death:*		
			If Deceased, Please List Any Living Children		

Marital Status

Proposed Client	Spouse
Check the number marriage this is: ☐ 1st ☐ 2nd ☐ 3rd ☐ Other	*Check the number marriage this is: ☐ 1st ☐ 2nd ☐ 3rd ☐ Other*
Please list any agreements in place (prenuptial agreements, spousal support, etc.)	*Please list any agreements in place (prenuptial agreements, spousal support, etc.)*

Please list any potential recipients of your estate who may be at risk for bankruptcy, addictions, spendthrift, imminent divorce or other exposure/liability, etc.

_____

_____

Agents *(attach additional pages, if needed) – these are the individuals which you would like to name as your healthcare agent, or trustee, etc. (note: they do not have to be in order) if they are not already listed on the previous pages.*

Agent 1	*Suffix*	*Last Name*	*First Name*	*Middle Name*
	Street Address			*City, State, ZIP code*
	Home Phone			*Cell Phone*
	Email address			
	Relationship			
Agent 2	*Suffix*	*Last Name*	*First Name*	*Middle Name*
	Street Address			*City, State, ZIP code*
	Home Phone			*Cell Phone*
	Email address			
	Relationship			

Do you (or your spouse, if applicable) have any current health concerns or pre-existing conditions?

Proposed Client	Spouse
Please list diagnoses/conditions:	*Please list diagnoses/conditions:*
Please check any difficulty with activities of daily living: ☐ *Walking* ☐ *Grooming* ☐ *Dressing* ☐ *Toileting* ☐ *Eating* ☐ *Transferring from bed to chair* ☐*Other:*	*Please check any difficulty with activities of daily living:* ☐ *Walking* ☐ *Grooming* ☐ *Dressing* ☐ *Toileting* ☐ *Eating* ☐ *Transferring from bed to chair* ☐*Other:*
Please list any Health Care Agencies currently providing services:	*Please list any Health Care Agencies currently providing services:*
Please list your Health Insurance Carrier(s), if applicable	*Please list your Health Insurance Carrier(s), if applicable*
Do you have Long-Term Care Insurance? ☐ *Yes* ☐ *No* ***If yes, please bring your policy or summary statements to your meeting***.	*Do you have Long-Term Care Insurance?* ☐ *Yes* ☐ *No* ***If yes, please bring your policy or summary statements to your meeting***.

Assets

Real Estate

Street Address, City, State	*Name on Deed*	*Fair Market Value*	*Tax Assessed Value*	*Mortgage*
1.				
2.				

Bank Accounts

Bank Name	*Name on Account*	*Balance*	*Type of Account*
1.			□ *Savings/Checking* □ *CD* □ *Other*
2.			□ *Savings/Checking* □ *CD* □ *Other*
3.			□ *Savings/Checking* □ *CD* □ *Other*
4.			□ *Savings/Checking* □ *CD* □ *Other*
5.			□ *Savings/Checking* □ *CD* □ *Other*

Retirement Accounts *(Examples include IRAs/401(k), profit sharing, TSA/TSCA/403(b), employee savings plan, SEPs, Keoghs, 457)*

Company	*Type of Account*	*Owner/Beneficiary*	*Current Value*
1.			
2.			
3.			

Mutual Funds or Brokerage Accounts (Non-Retirement)

Name of Company	*Account Owner*	*Current Value*
1.		
2.		
3.		

Treasury Securities (Bills/Notes/Bonds)

Account Owner(s)	*Current Value*
1.	
2.	
3.	

Stocks (not held in a Brokerage Account)

Name of Company	*Name on Stock*	*Current Value*
1.		
2.		
3.		

Savings Bonds

Name on Bonds	*Face Amount*	*Current Value*
1.		
2.		
3.		

Annuities (Not in Retirement Accounts)

Company	*Owner/ Beneficiary*	*Type*	*Current Value or Monthly Income*	*Date Purchased*
1.		□ *Immediate* □ *Deferred*		
2.		□ *Immediate* □ *Deferred*		
3.		□ *Immediate* □ *Deferred*		

Life Insurance

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

Name of Company	*Insured*	*Owner*	*Beneficiary*	*Type*	*Death Benefit Value*	*Cash Value (if whole life)*	*Face Value*
1.				□ *Whole Life* □ *Term*			
2.				□ *Whole Life* □ *Term*			
3.				□ *Whole Life* □ *Term*			
4.				□ *Whole Life* □ *Term*			

Please describe any interest that you may own in a business

_____
_____
_____
_____

Gifts/Transfers

Please list any gift of $1000 or more made in the last five years to any person.

Recipient	*Date*	*Amount*
Recipient	*Date*	*Amount*
Recipient	*Date*	*Amount*

Have you transferred, conveyed, sold, or otherwise disposed of any homes, cottages, or land within the last five (5) years?

□ *No* □ *Yes* *Explain:*_____

Monthly Income (Gross)

	Income Source	*Proposed Client*	*Spouse*
A.	*Gross Social Security Benefits*	*$*	*$*
B.	*Gross Pension*	*$*	*$*
C.	*Gross Salary or Wages*	*$*	*$*
D.	*Interest*	*$*	*$*
E.	*Dividends*	*$*	*$*
F.	*Annuity Income*	*$*	*$*
G.	*Other*	*$*	*$*
H.	*Other*	*$*	*$*
TOTAL MONTHLY INCOME		*$*	*$*

Monthly Costs of Care

	Proposed Client	*Spouse*
1. Nursing Home	*$*	*$*
2. Personal Care in Home	*$*	*$*
3. Health Insurance	*$*	*$*
4. Prescriptions	*$*	*$*
5. Long Term Care Insurance	*$*	*$*
6. Other	*$*	*$*
TOTAL MONTHLY COST	*$*	*$*

Legal and Financial Documents

Please indicate any legal documents that you currently have in place. We strongly encourage you to bring any them - especially deeds and trusts - to your appointment in order for us to fully evaluate your case.

Check, and bring with you, all that apply:

Legal Documents

□ Deeds
□ Wills
□ Trusts
□ Powers of Attorney
□ Health Care Proxies
□ Guardianship Documents

Financial Documents

□ Life Insurance Policies
□ Long Term Care Insurance Policies
□ Most Recent financial statement(s) for each account

Do you have any other Legal issues that we should be aware of?

□ *No* □ *Yes* *Explain:*_____

_____

What are your goals for meeting with Senior Resource Center? *(check all that apply)*

□ Obtain benefits for long term care
□ Avoid Probate
□ Planning for special needs person
□ Keeping it Simple
□ Other Goal _____

Signature

I represent to Senior Resource Center, Inc. that the information contained in this intake form is accurate and complete, and that the I understand that SRC will rely on this information that is being furnished. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by SRC may not be appropriate.

Signature of Client or Client Representative

_____

Date

_____