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RECEIPT AND COMPLETION OF THIS DOCUMENT DOES NOT ESTABLISH AN ATTORNEY-CLIENT RELATIONSHIP.

Via Download

Prospective Client

Re: Prospective Client Information Worksheet for Estate Planning

Dear Prospective Client,

In order to start work on your estate planning documents, I must first obtain some information about you, your family, your estate, and your wishes in the event of your death or incapacity. Please fully complete the remaining pages of this letter and return them to my office as soon as possible.

Please understand that the receipt of this Worksheet by The Duran Firm does not establish an attorney-client relationship. The Duran Firm will require pre-payment of its fees and the execution of the Attorney-Client Fee Agreement prior to accepting you as a client. We do, however, look forward to working for you.

Please do not hesitate to contact me should you have any questions.

Sincerely,

Michael A. Duran

Attachment

Client Information Worksheet

I. General Client Information.

A. Client

1. Formal Name: _____
First Middle Last

2. Aliases: _____

3. Address: _____
Street Apt #

City County State Zip Code

4. Phone Number: _____
() Home () Work

5. Date of Birth: _____ / _____ / _____

6. U.S. Citizen: Yes No

B. Spouse

1. None. Yes No

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C. Child #1

1. Formal Name: _____
First Middle Last
2. Address: Same as Clients **OR**
3. _____
Street Apt #

City County State Zip Code
4. Date of Birth: _____ / _____ / _____
5. Parents' Names: _____
Mother Father
6. Child Living? Yes No
7. Special Needs Child? Yes No

D. Child #2

1. Formal Name: _____
First Middle Last
2. Address: Same as Clients **OR**
3. _____
Street Apt #

City County State Zip Code
4. Date of Birth: _____ / _____ / _____
5. Parents' Names: _____
Mother Father
6. Child Living? Yes No
7. Special Needs Child? Yes No

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E. Child #3

1. Formal Name: _____
First Middle Last
2. Address: Same as Clients **OR**
3. _____
Street Apt #

City County State Zip Code
4. Date of Birth: _____ / _____ / _____
5. Parents' Names: _____
Mother Father
6. Child Living? Yes No
7. Special Needs Child? Yes No

F. Child #4

1. Formal Name: _____
First Middle Last
2. Address: Same as Clients **OR**
3. _____
Street Apt #

City County State Zip Code
4. Date of Birth: _____ / _____ / _____
5. Parents' Names: _____
Mother Father
6. Child Living? Yes No
7. Special Needs Child? Yes No

Continue on back if necessary.

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II. Planning Your Will

A. Client

1. Prior Estate Planning.

a. Does Client presently have a Will? Yes No

b. Is Client a beneficiary, trustee (singly or jointly), or creator of a trust? Yes No

2. Desired Estate Plan

a. Are you going to leave everything to your your children, share and share alike? Yes No

If "No", then please describe in general terms how you wish to distribute the remaining property under your will:

b. Beneficiaries to be named in Will

If you are going to leave property to persons other than your children, then please provide information regarding those Beneficiaries.

i. Beneficiary

Name: _____
First Middle Last

Aliases: _____

Relation: _____

Continue on back if necessary.

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c. If any of your children or beneficiaries are minors, do you want the property to be distributed to those minors outright or held in trust until a certain date? (choose one):

- Outright; (Please Initial _____) OR
- In Trust until each reaches age _____, then outright; OR
- In Trust with distributions at the following ages and amounts:
 1/3 at age _____;
 1/3 at age _____; and
 Remaining share at age _____.

d. Executor

Please designate the person who will be responsible for probating your will, filing the estate tax return, if necessary, and distributing the assets to the beneficiaries. This person must not be a minor, have ever been convicted of a felony, or ever adjudicated as incapacitated.

- i. Executor: _____
 First Middle Last
- ii. Alternate Executor: _____
 First Middle Last
- iii. Second Alt. Executor: _____
 First Middle Last

e. Trustee

Please designate the person who will be responsible for the long-term management of property placed in trust by your Will.

- i. Same as the Executor designations Yes No
 If "No", please list Trustees below:
- ii. Trustee: _____
 First Middle Last
- iii. First Alt. Trustee _____
 First Middle Last
- iv. Second Alt. Trustee: _____
 First Middle Last

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f. Guardian of Minor Children's Estate

Please designate the person who will take care of any property that is in your children's names (not to include property placed in trust by your Will).

v. Same as the Trustee designations Yes No
If "No", please list Guardians below:

vi. Guardian: _____
First Middle Last

vii. First Alt. Guardian: _____
First Middle Last

viii. Second Alt. Guardian: _____
First Middle Last

g. Guardian of Minor Children's Person

Please designate the person who will take physical care of your minor children should both parents die.

i. Same as the Trustee designations Yes No
If "No", please list Guardians below:

ii. Guardian: _____
First Middle Last

iii. First Alt. Guardian: _____
First Middle Last

iv. Second Alt. Guardian: _____
First Middle Last

h. Do you want guardians appointed to take care of your children in the event of your incapacity, as well as death? Yes No

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III. Planning for Your Incapacity

A. Financial Agent

Please designate a Financial Agent in case you become incapacitated. The agent will be the person who will be responsible for handling your financial affairs in the event you are unable to handle them yourself.

1. Client

a. Financial Agent:

Name:

First Middle Last

Address:

Street Apt#

City State Zip Code

b. First Alternate Financial Agent:

Name:

First Middle Last

Address:

Street Apt#

City State Zip Code

c. Please list the powers to be granted to agents (check all that apply).

- Real property transactions;
- Tangible personal property transactions;
- Stock and bond transactions;
- Commodity and option transactions;
- Banking and other financial institution transactions;
- Business operating transactions;
- Insurance and annuity transactions;
- Estate, trust, and other beneficiary transactions;
- Claims and litigation;
- Personal and family maintenance;
- Benefits from social security, Medicare, Medicaid, or other governmental programs or civil or military service;
- Retirement plan transactions;
- Tax matters.

d. Please list any special instructions limiting or extending the powers granted to your agent:

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III. Planning for Your Incapacity (Cont.)

B. Health Care Agent

Please designate a Health Care Agent in case you become incapacitated. The agent will be the person who will make medical decisions for you in the event you are unable to make them for yourself.

1. Client

a. Health Care Agent:

Name:

First Middle Last

Address:

Street Apt#

City State Zip Code

b. First Alternate Health Care Agent:

Name:

First Middle Last

Address:

Street Apt#

City State Zip Code

c. Please list any special instructions limiting the decision making authority of your agent:

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III. Planning for Your Incapacity (Cont.)

C. Guardian

Please designate a Guardian for yourself and your finances in the event you become permanently incapacitated.

1. Client

a. Guardian of Your Person. Please designate a Guardian for yourself (i.e. the person who will take physical care of you) in the event you become permanently incapacitated.

i. Guardian of the Person:

Name: _____
First Middle Last

ii. Alternate Guardian of the Person:

Name: _____
First Middle Last

b. Guardian of Your Estate. Please designate a Guardian for your estate (i.e. the person who will take care of your property) in the event you become permanently incapacitated.

i. Guardian of the Estate:

Name: _____
First Middle Last

ii. Alternate Guardian of the Estate:

Name: _____
First Middle Last

c. Disqualification. Please list any persons who are *expressly disqualified* from serving as Guardian in any capacity:

Name: _____
First Middle Last

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III. Planning for Your Incapacity (Cont.)

D. Living Will or Directive to Physicians

A Living Will, also known as an "Advance Directive" or "Directive to Physicians" is a document that is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury.

1. Client

- a. If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care (CHOOSE ONE):

I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

I request that I be kept alive in this terminal condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

- b. If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care (CHOOSE ONE):

I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

I request that I be kept alive in this irreversible condition using available life-sustaining treatment. (THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

- c. Additional requests: (After discussing with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

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IV. Planning for Your Children’s Medical Care

A. Health Care Surrogate: Please designate the person who will make medical decisions for your minor children in the event you cannot be located.

1. Health Care Surrogate

a. Name:

First Middle Last

b. Relationship to Parents:

c. Address:

Street Apt#

City State Zip Code

d. Home Phone No.:

() _____

2. Alternate Health Care Surrogate

a. Name:

First Middle Last

b. Relationship to Parents:

c. Address:

Street Apt#

City State Zip Code

d. Home Phone No.:

() _____

B. The authority granted to the Surrogate shall include, but not be limited to the following (check all that applied):

- To request, review, and receive any and all medical, hospital and related information and records, and to execute a release or other document required to obtain such information;
- To consent to the disclosure of medical and related information to others;
- To employ and discharge medical and related personnel;
- To consent, refuse consent, or withdraw consent to medical care, treatment, service or procedure, subject to directions expressed in an effective Directive to Physicians;
- To provide appropriate relief from pain;
- To arrange for care and lodging in a hospital or other medical facility;
- To grant releases to health care professionals or institutions to assure that my wishes for my children's care are fulfilled;
- To authorize anatomical gifts;
- To arrange to hire and to pay the salaries of employees, nurses and similar health care providers, and to see that required tax returns are filed; and
- Other: _____

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CERTIFICATION STATEMENT (REQUIRED)

I certify that the combined value of my gross estate (including but not limited to real estate, cash, stocks, bonds, financial accounts, businesses, decedent-owned life insurance policies, and other personal property assets) does not exceed \$_____.

GROSS VALUE OF ESTATE

I understand that The Duran Firm and its attorneys will rely on the information I have provided in this Certification Statement in order to draft estate planning documents that are appropriate for the value of my estate and I have estimated this value to the best of my ability.

SIGNED this _____ day of _____, 20____.

Prospective Client