THE DURAN FIRM, PLLC

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Prospective Client Via Download

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.

> Before you start completing the Worksheet, save the Worksheet to a new file (usually by clicking the disk icon, "Save" or "ctrl + S"). As you are completing the worksheet, periodically save your work. When you are done entering the information, save the file one last time and either e-mail it to us as an attachment or print the file and fax it to us.

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

Sincerely,

Michael A. Duran

Michael A. Duran

Attachment

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Client Information Worksheet

1. General Client Information.

A. Client

1. Legal Name: _____ (Full Name)
2. Aliases: _____
3. Address: _____ (Street)
   _____ (City, State & Zip Code)
4. E-Mail Address: _____
5. Phone Number: _____ (Home) _____ (Work)
6. U.S. Citizen: Yes ☐ No ☐
7. Are you a beneficiary, trustee (singly or jointly), or creator of a trust? Yes ☐ No ☐

B. Spouse Yes ☐ No ☐

1. Legal Name: _____ (Full Name)
2. Aliases: _____
3. E-Mail Address: _____
4. Phone Number: _____ (Home) _____ (Work)
5. U.S. Citizen: Yes ☐ No ☐
6. Is your spouse a beneficiary, trustee (singly or jointly), or creator of a trust? Yes ☐ No ☐

C. Preferred method of payment: Cash ☐ Check ☐ Credit Card (PayPal) ☐

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2. List all children born to or adopted by you whether living or deceased.

A. Child #1

1. Legal Name: _____ (Full Name)
2. Date of Birth: _____
3. Parents' Names: _____ (Mother) _____ (Father)
4. Child Living? Yes ☐ No ☐
5. Child with Special Needs? Yes ☐ No ☐

B. Child #2

1. Legal Name: _____ (Full Name)
2. Date of Birth: _____
3. Parents' Names: _____ (Mother) _____ (Father)
4. Child Living? Yes ☐ No ☐
5. Child with Special Needs? Yes ☐ No ☐

C. Child #3

1. Legal Name: _____ (Full Name)
2. Date of Birth: _____
3. Parents' Names: _____ (Mother) _____ (Father)
4. Child Living? Yes ☐ No ☐
5. Child with Special Needs? Yes ☐ No ☐

Continue on back if necessary.

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3. Last Will and Testament

A. Information regarding estate.

What is the estimated value of your gross estate (including but not limited to real estate, cash, financial accounts, businesses, life insurance policies, revocable trusts, personal property assets, and all other property that transfers on your death): $_____
Value

B. Desired Estate Plan

Are you going to leave everything to your spouse and then your children, share and share alike? Yes☐ No ☐

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

_____

_____

_____

_____

_____

C. 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.

1. Primary Executor: Spouse ☐ ***OR***

_____
Full Name

2. First Alt. Executor: _____
Full Name

3. Second Alt. Executor: _____
Full Name

D. Please designate the agents who will take care of any property that is in your children's names or left in trust for your children (Do not list your spouse).

1. Primary Financial Agent: _____
Full Name

2. First Alt. Financial Agent: _____
Full Name

3. Second Alt Financial Agent: _____
Full Name

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4. Financial Agent in case of your Incapacity

A. Please designate financial agents who will be responsible for handling your financial affairs in the event you are unable to do so. These persons will be named as your Agents in a Special Durable Power of Attorney and will be named as the Guardians of your Estate in a Designation of Guardian form.

1. Primary Financial Agent: Spouse ☐ ***OR***

(A) Name: _____
Full Name

(B) Address: _____
Street

_____
City, State & Zip

2. Alternate Financial Agent Spouse ☐ ***OR***

(A) Name: _____
Full Name

(B) Address: _____
Street

_____
City, State & Zip Code

3. 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.

4. Do you want your Agent to have the power to make gifts not to exceed the amount of the annual gift tax exclusion? Yes ☐ No ☐

5. When do you want your power of attorney to take effect? Immediately ☐ Upon my disability ☐

6. Please list any special instructions limiting or extending the powers granted to your Agent: _____

_____

_____

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5. Medical Agent in case of your Incapacity

A. Please designate medical agents who will be responsible for making personal and medical decisions for you in the event you are unable to do so. These persons will be named as your Agents in a Medical Power of Attorney and will be named as the Guardians of your Person in a Designation of Guardian form.

1. Primary Health Care Agent Spouse ☐ ***OR***

(A) Name: _____
Full Name

(B) Address: _____
Street

_____
City, State & Zip Code

_____
Phone Number

2. Alternate Health Care Agent Spouse ☐ ***OR***

(A) Name: _____
Full Name

(B) Address: _____
Street

_____
City, State & Zip Code

_____
Phone Number

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

_____

_____

_____

7. **Living Will**

A. Your wishes in case of permanent or terminal medical incapacity to be expressed in your Living Will or Directive to Physicians.

1. 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.)\

2. 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.)

3. 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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8. **Care and Custody of Your Minor Children**

A. Please designate the persons who will take physical care of your minor children should both parents die or become unavailable to make healthcare decisions.

1. Primary Physical Guardian /Health Care Surrogate:

(A) Name: _____
Full Name Phone Number

(B) Address: _____
Street, City, State & Zip Code

2. Alt. Physical Guardian /Health Care Surrogate:

(A) Name: _____
Full Name Phone Number

(B) Address: _____
Street, City, State & Zip Code

3. Second Alt. Physical Guardian /Health Care Surrogate:

(A) Name: _____
Full Name Phone Number

(B) Address: _____
Street, City, State & Zip Code

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

☐ **All powers; OR**

☐ 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: _____

C. Please list any limitations on the decision making authority of the temporary Health Care Surrogate: _____

_____

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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, revocable trusts, all other personal property assets, and any other asset that will transfer upon my death) does not exceed $_____.

GROSS VALUE OF ESTATES

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 AND ACCEPTED this _____ day of _____, 20____.

_____

Prospective Client's Signature