



CLIENT INTAKE FORM

(Single)

We are a comprehensive planning firm, which means we ask for a lot of information for an initial consultation. The time you spend in advance of your initial consultation in completing this form will enable us to serve you more efficiently. All information provided will be kept confidential and securely stored.

In order for us to accurately evaluate your current situation, we ask that you provide the following (as they apply) to our firm at your initial meeting or in advance.

1. Current Power of Attorney document;
2. Current will;
3. Deed(s) to any real estate owned;
4. The current value of all bank and/or investment accounts;
5. The current value of any stock and/or bonds owned;
6. A copy of all life insurance policies; and
7. Current monthly income received.

Feel free to provide this completed form and above information by **FAX** to (260) 824-8855, or **MAIL** to Dale, Huffman & Babcock, 30 Premier Avenue, Bluffton, Indiana 46714, or visiting one of our offices located in Bluffton at 30 Premier Avenue or at 406 South Scott Road, Fort Wayne, Indiana 46814. We also offer a secure client portal that we use for exchange of documents. If you would like more information regarding this client portal, please contact our administrative staff at Admin@dhblaw.com.

Thank you for contacting Dale, Huffman & Babcock Lawyers. We look forward to working with you.



Date: _____

CLIENT INTAKE FORM

(Single)

The information requested on this questionnaire will be used in providing asset protection, estate planning, Medicaid planning advice, and/or other legal services. Please complete the entire form with accurate information. Please add additional pages as necessary.

Personal Information:

A. Client's Name: _____
First M.I. Last

Prefer to be called: _____ Date of Birth: _____

Social Security No.: _____ Are you a veteran? Y N

Marital Status: Single Married Divorced Widow/Widower

Spouse's Name: _____

Date Divorce Finalized: _____ Date of Spouse's Death: _____

If married, please explain why you are not living with your spouse: _____

Last grade completed: _____ U.S. Citizen? Y N

County of Residence: _____

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: _____ Cell Phone: _____

Email: _____

Do you have a will? Y N

Have you created any type of trust agreement? Y N

Do you own a business? Y N

Have you been convicted of a felony? Y N

B. Contact Person/POA: _____
First M.I. Last

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: _____ Cell Phone: _____

Email: _____ Relation to Client: _____

C. Names and addresses of each of your children (including deceased). Please add additional pages if needed.

1. Name: _____
First M.I. Last Date of Birth Gender Marital Status
Mailing Address: _____
Street City State Zip
Contact Phone: _____ Email: _____

2. Name: _____
First M.I. Last Date of Birth Gender Marital Status
Mailing Address: _____
Street City State Zip
Contact Phone: _____ Email: _____

3. Name: _____
First M.I. Last Date of Birth Gender Marital Status
Mailing Address: _____
Street City State Zip
Contact Phone: _____ Email: _____

4. Name: _____
First M.I. Last Date of Birth Gender Marital Status
Mailing Address: _____
Street City State Zip
Contact Phone: _____ Email: _____

5. Name: _____
First M.I. Last Date of Birth Gender Marital Status
Mailing Address: _____
Street City State Zip
Contact Phone: _____ Email: _____

Do any of your children receive Social Security Disability or Supplemental Social Security (SSI) benefits? Y N

If yes, who? _____

D. Have you or anyone in your family filed for Medicaid, Food Stamps/SNAP, or TANF benefits before? Y N

E. Has anyone lived with you, or have you lived with anyone during the last two years? Y N
If yes, please explain the circumstances:

F. Are you in a nursing home, assisted living, or rehab center? Y N

If yes, please complete the following:

Name of Facility: _____

Was admission from: Home Hospital Other Facility

Date of Admission: _____

G. Have you been involved in an accident within the past two years in which litigation is pending? Y N

Loans:

Does anyone presently owe you any money (or other debt)? Y N

If yes, do you have written documentation signed by the debtor? Y N

Please list the amount owed to you for each loan and payment terms:

Monthly Income:

Social Security: _____

Pension: _____

Pension: _____

Farm: _____

Other: _____

Total: _____

Income Taxes:

Are you required to file a federal income tax return? Y N

Do you claim any dependents? Y N

Do you intend to file federal income taxes next year? Y N

Have you ever filed federal or state gift tax returns? Y N

Expenses:

Supplemental Health Insurance:

Monthly Premium: _____ Company Name: _____

Do you have Medicare Part C coverage? Y N

Medicare Part D (prescription) Coverage

Monthly Premium: _____ Company Name: _____

Assets: Please be aware, Family and Social Services Administration checks assets owned by a Medicaid applicant over the past 5 years using an Asset Verification System. Please list all assets your name appears on, even if you are not the primary owner of the asset. Please add additional pages as necessary.

A. Do you have nursing home/long-term care insurance? Y N

B. Do you have a financial advisor and/or accountant? Y N If yes, please provide his/her name, company name, address, and phone number:

C. What real estate do you own? Please add additional pages as necessary.

Address: _____
Street City State acreage

Address: _____
Street City State acreage

Address: _____
Street City State acreage

D. What vehicles do you own, including mobile homes, RVs, campers, ATVs, boats, golf carts, mopeds, etc.? Please add additional pages as necessary.

Year	Make	Model	Year	Make	Model
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

E. Have you sold, transferred, or traded any real estate or vehicles in the last 5 years? Y N
If yes, please list what was sold/transferred/traded and when. _____

F. What bank accounts is your name on individually or jointly. Please add additional pages as necessary.

Bank Name: _____	Owner: _____
Account Type: _____	Account #: _____
Current Balance: _____	

Bank Name: _____	Owner: _____
Account Type: _____	Account #: _____
Current Balance: _____	

Bank Name: _____	Owner: _____
Account Type: _____	Account #: _____
Current Balance: _____	

G. Other Investments (IRAs, 401(k), mutual funds, brokerage accounts, annuities, etc.). Please add additional pages as necessary.

Company Name: _____
Account Type: _____
Current Balance: _____

Owner: _____
Account #: _____

Company Name: _____
Account Type: _____
Current Balance: _____

Owner: _____
Account #: _____

Company Name: _____
Account Type: _____
Current Balance: _____

Owner: _____
Account #: _____

H. Life Insurance. Please add additional pages as necessary.

Company Name: _____
Insured: _____
Cash Surrender Value: _____

Owner: _____
Death Benefit: _____
Type: Whole Term Group

Company Name: _____
Insured: _____
Cash Surrender Value: _____

Owner: _____
Death Benefit: _____
Type: Whole Term Group

I. Do you own any stocks? Y N
If yes, please provide your current financial statement.

J. Do you own any savings bonds? Y N
If yes, please provide a copy of each bond.

K. Do you own prepaid funeral arrangements? Y N
If yes, please provide us with all documents pertaining to such arrangements.

L. Do you own cemetery or burial plots? Y N
If yes, please provide documentation of ownership.

Gifts/Transfers:

Please list all gifts (cash, real estate, vehicles, etc.) made within the last five (5) years (no matter how small or for what reason, except gifts to charities and churches). Please add additional pages as necessary.

<u>Date</u>	<u>Amount</u>	<u>To Whom</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special Considerations:

Are you currently the beneficiary of anyone else's trust, expecting an inheritance in the future, or expecting a large lump sum payment of money (such as a lawsuit settlement)? Y N

If yes, please explain: _____

Do any of your intended beneficiaries have special educational, medical, or physical needs? Y N

If yes, please explain: _____

Do you provide major financial support to adult children or other beneficiaries that is considered to be an advancement or part of their estate inheritance? Y N

If yes, please explain: _____

Please list any charitable organizations to which you are considering making gifts from your estate:

Referral:

Who referred you to our office?

Name

Address (street, city, state, zip)

Client Signature

Date