Ancillary Forms Worksheet

MVP Law Group, A PC
Estate and Trust Planning

USING THIS ORGANIZER WILL ASSIST US IN DESIGNING AN ESTATE PLAN THAT MEETS YOUR GOALS.
ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL.

IF POSSIBLE, PLEASE RETURN THE COMPLETED WORKSHEET TO OUR OFFICE PRIOR TO YOUR APPOINTMENT VIA MAIL OR FAX.

Part I
Personal Information

Client's Full Legal Name ____

(name most often used to title property and accounts)

Also Known As ____

(other names used to title property and accounts)

Birth date ____________________ SS# ____________________ US Citizen? YES/NO

Address ____

Cell Phone ____________________ Home Number ____________________

E-mail Address ____________________

MARITAL STATUS: ❑ Married ❑ Divorced ❑ Widowed ❑ Single (If single skip to next section)

Spouse Full Legal Name: ____________________ Marriage Date: ____________________

Address: ____

Birthdate: ___/____/________

Phone Number: ____________________

Email address: ____________________

Children

Use full legal name:

Name **Birth date** **Relationship**

____________________ ____________________ ____________________

Address ____________________ Cell Phone: ____________________ Email: ____________________

Name **Birth date** **Relationship**

____________________ ____________________ ____________________

Address ____________________ Cell Phone: ____________________ Email: ____________________

Name **Birth date** **Relationship**

____________________ ____________________ ____________________

Address ____________________ Cell Phone: ____________________ Email: ____________________

Name **Birth date** **Relationship**

____________________ ____________________ ____________________

Address ____________________ Cell Phone: ____________________ Email: ____________________

Name **Birth date** **Relationship**

____________________ ____________________ ____________________

Address ____________________ Cell Phone: ____________________ Email: ____________________

GUARDIAN FOR MINOR CHILDREN: If you have any children under the age of 18, list in order of preference who you wish to be guardian.

Name and Address	**Relationship**

**Please list the guardians in the order they are to serve.

Other Family Members You wish to Add

(Example: Parents, siblings)

Use full legal name:

Name ______________________ **Birth date** __________ **Relationship** __________

Address ______________________ Cell Phone: __________ Email: __________

Name ______________________ **Birth date** __________ **Relationship** __________

Address ______________________ Cell Phone: __________ Email: __________

Name ______________________ **Birth date** __________ **Relationship** __________

Address ______________________ Cell Phone: __________ Email: __________

Name ______________________ **Birth date** __________ **Relationship** __________

Address ______________________ Cell Phone: __________ Email: __________

Additional Information (Comments)

CLIENT INFORMATION

Part II

Design Information

PERSONS TO ACT FOR YOU: If you were unable to make financial or health decisions for yourself, who would you want to make those decisions for you?

IF I HAVE DESIGNATED MORE THAN ONE AGENT, THE AGENTS ARE TO ACT (choose one):

A. SEPARATELY

B. TOGETHER

PERSONS TO ACT FOR YOU: (Optional to list up to three)

1. ______________________________
2. ______________________________
3. ______________________________

C. **If not listed in Part I please provide their information*** (Place in order) Name 1 Birth date Relationship

______________________________ ______________ ______________

Address ______________________________ Cell Phone: ______________ Email: ______________

Name 2 Birth date Relationship

______________________________ ______________ ______________

Address ______________________________ Cell Phone: ______________ Email: ______________

Name 3 Birth date Relationship

______________________________ ______________ ______________

Address ______________________________ Cell Phone: ______________ Email: ______________

END-OF-LIFE DECISIONS:
I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice ***(select one)***

a. Choice NOT to prolong life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits

b. Choice to prolong life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

ORGAN DONATION (OPTIONAL):

DONATION OF ORGANS, TISSUES, AND PARTS AT DEATH

(3.1) ☐ Upon my death, I give my organs, tissues, and parts (mark box to indicate yes). By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

My donation is for the following purposes (please check mark the ones you allow):

(a) Transplant

(b) Therapy

(c) Research

(d) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

____

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form

PRIMARY PHYSICIAN (OPTIONAL)

(4.1) I designate the following physician as my primary physician:

____

(name of physician)

____

(address)

____

(phone)

ADDITIONAL COMMENTS:

____

____

____

____

____

____

SPOUSE INFORMATION

Part II (Spouse Information)

Design Information

PERSONS TO ACT FOR YOU: If you were unable to make financial or health decisions for yourself, who would you want to make those decisions for you?

IF I HAVE DESIGNATED MORE THAN ONE AGENT, THE AGENTS ARE TO ACT (choose one):

A. SEPARATELY

B. TOGETHER

PERSONS TO ACT FOR YOU: (Optional to list up to three)

1. ______________________________
2. ______________________________
3. ______________________________

C. **If not listed in Part I please provide their information*** (Place in order) Name 1 ______________________ Birth date ____________ Relationship ____________

Address ______________________ Cell Phone: ____________ Email: ____________

Name 2 ______________________ Birth date ____________ Relationship ____________

Address ______________________ Cell Phone: ____________ Email: ____________

Name 3 ______________________ Birth date ____________ Relationship ____________

Address ______________________ Cell Phone: ____________ Email: ____________

END-OF-LIFE DECISIONS:

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice ***(select one)***

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PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

____

(name of physician)

____

(address)

____

(phone)

ADDITIONAL COMMENTS:

____
____
____
____
____
____