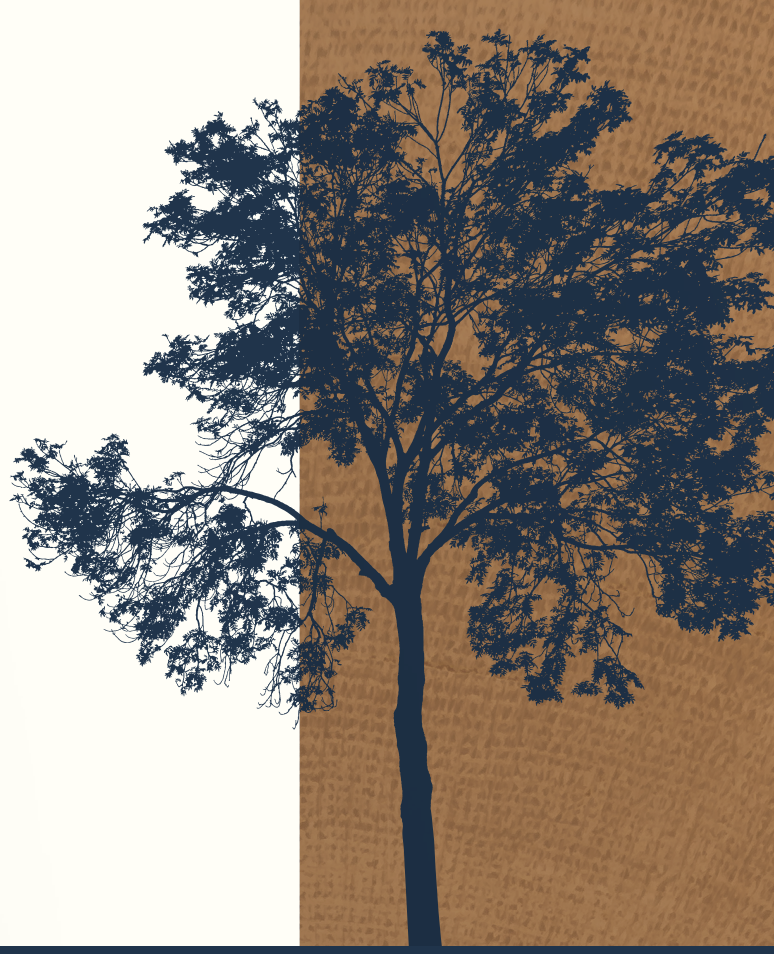

LLG
LITTORNO
LAW GROUP

Estate Planning Organizer

Richard A. Littorno
Elder Law Attorney
LL.M. (Tax)

- Estate & Tax Planning
- VA Pension & Medi-Cal Benefits
- Trust & Probate Administration
- Asset Protection Strategies

(800) 689-4211

Pittsburg Office
2211 Railroad Avenue
Pittsburg, CA 94565
(925) 432-4211
(925) 432-3516, fax

San Diego Office
16935 W, Bernardo Drive
Suite 100
San Diego, CA 92127
(760) 525-3140
(858) 798-4077, fax

Pleasant Hill & South Bay Area
By Appointment

2023 Estate Planning Organizer

CLIENT INFORMATION			
Client		**Spouse/Partner**	
Full Legal Name:		**Full Legal Name:**	
Gender:		Gender:	
U.S Citizen?	Yes ☐ No ☐	U.S Citizen?	Yes ☐ No ☐
Date of Birth:		Date of Birth:	
Date of Death:		Date of Death:	
Home/Work Phone:		Home/Work Phone:	
Cell Phone:		Cell Phone:	
Email:		Email:	
Principal Residence Address:			
Above Owned?	Yes ☐ No ☐	Plans to Sell?	Yes ☐ No ☐
Additional Property Address:			
Additional Property Address:			
Marital Status:	Married ☐ Domestic Partners ☐ Single ☐ Divorced ☐ Widowed ☐		
Date/Location of Marriage(s):		How/When Terminated:	
Previous Trust?		Date Created:	

SUCCESSOR TRUSTEE / FINANCIAL POWER OF ATTORNEY *(SERVING AFTER SPOUSE/PARTNER)*			
First Alternate		**Second Alternate**	
Full Legal Name:		**Full Legal Name:**	
Relationship:		Relationship:	
Phone Number:		Phone Number:	
Address:		Address:	

HEALTH CARE AGENT *(SERVING AFTER SPOUSE/PARTNER)*			
Client Contact's Agent		**Spouse/Partner's Health Care Agent**	
Full Legal Name:		**Full Legal Name:**	
Relationship:		Relationship:	
Phone Number:		Phone Number:	
Address:		Address:	
Client Contact's Agent (Alternate)		**Spouse/Partner's Health Care Agent (Alternate)**	
Full Legal Name:		**Full Legal Name:**	
Relationship:		Relationship:	
Phone Number:		Phone Number:	
Address:		Address:	

CHILDREN/BENEFICIARY INFORMATION

Full Legal Name:		Date of Birth, Gender:	
Home Phone:		Cell Phone:	
Email:		Special Needs?	
Relation:		Date of Death:	
Address:		List Spouse/Children/Dates of Birth:	
Full Legal Name:		Date of Birth, Gender:	
Home Phone:		Cell Phone:	
Email:		Special Needs?	
Relation:		Date of Death:	
Address:		List Spouse/Children/Dates of Birth:	
Full Legal Name:		Date of Birth, Gender:	
Home Phone:		Cell Phone:	
Email:		Special Needs?	
Relation:		Date of Death:	
Address:		List Spouse/Children/Dates of Birth:	
Full Legal Name:		Date of Birth, Gender:	
Home Phone:		Cell Phone:	
Email:		Special Needs?	
Relation:		Date of Death:	
Address:		List Spouse/Children/Dates of Birth:	

List Beneficiary Percentages by Name

Name:	% of Estate

NOTE: IF NOT LEAVING EQUAL SHARES TO CHILDREN, ATTACHED DETAILED REASONS AND INITIAL HERE: _______________

Guardian Desigination (For Minor Children)

Full Legal Name:		Relation:	
Address:		Phone:	
		Email:	

MONTHLY INCOME (GROSS):	SOURCE	CLIENT	SPOUSE
Social Security:		$	$
Long-Term Care:			
Pension / Retirement Income:			
Pension / Retirement Income:			
RMD from IRA/401K:			
Interest Income:			
L-T Military Service Pension:			
Service-Connected Disability Pension:			
Other Income			
Individual Totals:	**Grand Total:**	$	$
MEDICAL EXPENSES	PAYEE	CLIENT	SPOUSE
Assisted Living/Bd &Care:	Since?	$	$
In Home Care Provider:	Since?		
Medicare Premiums:			
Suppl. Health Insurance Premium:			
Dental Insurance Premium:			
Individual Totals:	**Grand Total:**	$	$
ASSETS	INSTITUTION	CLIENT	SPOUSE
Checking:			
Savings:			
Savings:			
CD:			
Money Market Funds:			
Bonds / Funds:			
Stocks / Funds:			
Annuities Type?			
IRA/401K / Other Qualified Funds: Type?			
IRA/401K / Other Qualified Funds: Type?			
Life Insurance: Cash Value/Death Benefit?			
Other Assets:			
Liabilities:			

Financial advisor contact information/date of last contact:

VA/MEDI-CAL CLIENTS ONLY

MILITARY SERVICE INFORMATION

Service Number:		Dates of Service:	
Branch of Service:		Place of Discharge:	

MEDICAL INFORMATION

Primary Care Physician:	Name:
Phone Number:	Address:

Has the claimant been diagnosed with:

☐ Dementia	☐ Alzheimer's Disease	☐ Dr's Letter of Incapacity Issued?
☐ Cognitive Impairment	☐ Parkinson's Disease	☐ Other:

Receive or need assistance with:

	Claimant	Spouse		Claimant	Spouse
Grooming	☐	☐	Bathing	☐	☐
Dressing	☐	☐	Personal Hygiene	☐	☐
Incontinence	☐	☐	Transferring	☐	☐
Medication Mang.	☐	☐	Financial	☐	☐
Cooking	☐	☐	Cleaning	☐	☐

Is the claimant able to drive a vehicle?	☐ Yes	☐ No
Is the claimant legally blind?	☐ Yes	☐ No

Care provider/facility:	Name/Address:

RESIDENTIAL INFORMATION

Address of owned residence:			
Plans for home:	Maintain ☐ Sell ☐ Rent ☐ One spouse to reside ☐		
Mortgage Balance?	$	Monthly Payment	$
Reverse Mortgage?	Yes ☐ No ☐	Balance	$
Surviving Spouse Remarried or Divorced from Veteran?	Yes ☐ No ☐	Details:	

Prior Application Details/Notes of Medical/Mental Conditions:

CLAIMANT INFORMATION

Claimant Name:			
Spouse Name:			
Trustee Name:			
Trustee Name:			