



## TRUST INTAKE INFORMATION

### Trustor Information (Owner of the Trust)

Name of Trust

Client's Full Name

Spouse Full Name

Address

City

State

Zip Code

Phone

Email

**Children**

Birth Date

Son/Daughter

Child #1

Child #2

Child #3

Child #4

Child #5

Child #6

**Trustee Information (Designated Person to Manage the Trust)**

**Do You Want Your Trustee to Manage Your Trust Independently: Yes\_\_\_\_\_ No\_\_\_\_\_**

**Do You Want Your Co-Trustee's to Work Jointly Together: Yes\_\_\_\_\_ No\_\_\_\_\_**  
(If You Selected YES, Check Co-Trustee Option on Each Trustee Name Below)

**Primary Trustee (Co-Trustee: Yes\_\_\_\_\_ No\_\_\_\_\_)**

**Full Name**

**Address**

**City State Zip Code**

**Phone Relationship**

**Alternate Trustee #1 (Co-Trustee: Yes\_\_\_\_\_ No\_\_\_\_\_)**

**Full Name**

**Address**

**City State Zip Code**

**Phone Relationship**

**Alternate/Successor Trustee #2 (Co-Trustee: Yes\_\_\_\_\_ No\_\_\_\_\_)**

**Full Name**

**Address**

**City State Zip Code**

**Phone Relationship**

## **Beneficiaries**

<b>Full Name</b>	<b>Relationship</b>	<b>Share %</b>
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**#1**

**#2**

**#3**

**#4**

**#5**

**#6**

**Distribution Instructions/Additional Beneficiaries**

# **Guardian for Minor Children**

## **Primary Guardian (First Choice)**

**Full Names**

**Relationship/Age**

**Address**

**City**

**State**

**Zip Code**

## **Alternate Guardian (Second Choice)**

**Full Names**

**Relationship/Age**

**Address**

**City**

**State**

**Zip Code**

## **Guardian Instructions**

**Name**

**Power of Attorney** (Check Here if Same as Trustee \_\_\_\_)

**Do You Want Your Agent to Manage Your Finances Independently:** Yes\_\_\_\_ No\_\_\_\_

**Do You Want Your Agents to Work Jointly Together:** Yes\_\_\_\_ No\_\_\_\_  
(If You Selected YES, Check Co-Agent Option on Each Agent's Name Below)

**Primary Agent** (Co-Agent: Yes\_\_\_\_ No\_\_\_\_ )

**Name**

**Address**

**City**

**State**

**Zip Code**

**Alternate Agent** (Co-Agent: Yes\_\_\_\_ No\_\_\_\_ )

**Name**

**Address**

**City**

**State**

**Zip Code**

**Indicate Which Powers Your Agent is Authorized to Manage**

**Financial Transactions**

**Government Benefits**

**Real Estate Transactions**

**Tax Returns**

**Securities/Bonds/Stocks**

**Conservator Estate**

**Financial Loans**

**Healthcare**

**Insurance**

**Business Interests**

**List Any Special Instructions for Your Agent to Manage Your Financial Affairs**

# Name

## Advanced Healthcare Directive

If you were unable to make healthcare decisions for yourself, who would you want to manage those decisions?

Please check here if the person you are appointing is the same as the Trustee

### Primary Agent (First Choice)

Full Name

Address

City

State

Zip Code

Phone

Relationship

### Alternate Agent (Second Choice)

Full Name

Address

City

State

Zip Code

Phone

Relationship

## Medical Directives

Select which of the following statements to be placed in your Advanced Directive.

**I Do Want** to be placed on machines or use artificial means or measures, if I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.

YES \_\_\_\_\_ NO \_\_\_\_\_

**I Do Want** life support if I am brain dead without brain activity for 48 hours.

YES \_\_\_\_\_ NO \_\_\_\_\_

**I Do Want** all sustaining life support to be relinquished if there is no chance for full recovery.

YES \_\_\_\_\_ NO \_\_\_\_\_

**I Do Want** to be intubated or placed on a Ventilator or breathing machine if necessary to stay alive.

YES \_\_\_\_\_ NO \_\_\_\_\_

**I Do Want** medications to alleviate severe symptoms of pain and discomfort, even if it hastens my death.

YES \_\_\_\_\_ NO \_\_\_\_\_

**I Do Want** CPR, AED or other resuscitation procedures to be performed on me if my heart were to stop beating.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

**I Do Want** a feeding tube or IV Procedures put in place, if I am not able to feed myself.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

**I Do Want** an Autopsy performed at the time of my death.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

**I Do Want** my organs and tissues to be made available for transplant purposes.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

**I Do Want** my Medical Agent to take whatever steps are necessary to keep me in a Personal Residence rather than placing me into a Nursing Home Facility.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

**I Do Want** my Medical Agent to obtain certification from a Physician if needed for psychological or substance treatments before my Agent may arrange for admission.

**YES**\_\_\_\_\_ **NO**\_\_\_\_\_

**List Any Specific Requests for Relief of Pain Management:**

**List Any Other Special Instructions:**

## **Primary Physician**

Name

Address

Phone

## **Burial Instructions**

**Cremation** \_\_\_\_\_

**Burial** \_\_\_\_\_

**Distribution of Ashes**

**Burial Plans**

## **Schedule of Assets**

### **Properties**

**Address**

**City State Zip Code**

**#2 Address**

**City State Zip Code**

**#3 Address**

**City State Zip Code**

### **Bank Accounts**

**Bank Name Type of Account**

### **Stocks & Bonds**

**(Stocks, Bonds, Investment Accounts)**

**Financial Institution Type of Account**

### **Life Insurance & Annuities Policies**

**Company Name Policy Type Amount**



## **Retirement Accounts**

Account Type (IRA, 401K, 403B)

Company Name

Account Type

Amount

## **Business Interests**

Sole Proprietorships, Partnerships, Corporations

Company Name

Type

% Ownership

## **Other Misc Assets**

## **Special Gifts**