ELDER APPRECIATION AND WILLS CLINIC INTAKE FORM

The volunteer attorney will use the information on this form to write up your will, power of attorney, and advance health care directive. Please answer each question completely and write neatly. Every question is important. If you do not know the answer to a question, write "*do not know*" in the space for the answer. Add additional pages if needed. For assistance in completing this form, please contact the Alaska Bar Association at **(907) 272-7469.** After sending us the completed form, we will call to schedule an appointment at the clinic **on October 17, 2025.**

Client No. 1 Information

1. What is your name, as shown on your government ID:_____
   _____
2. What are your nicknames or other names used? (If you don't have any, write "*none*")
   _____
3. Mailing Address:
   _____
4. Preferred Phone No. _____ Alternate Phone No. _____
5. Date of Birth: _____ Email: _____
6. If married (even if separated), what is your date of marriage? _____
   Legal name of spouse: _____
7. Marital Status (check all that apply):
   - ☐ Single
   - ☐ Married
   - ☐ Divorced
   - ☐ Separated
   - ☐ Widowed, date of death of your spouse: _____
8. Have you ever made a will before? ☐ Yes ☐ No
   If yes, when did you sign that will? _____
9. Do you know where the original will is? ☐ Yes ☐ No
   (If yes, bring it to the clinic, if possible)

10. Sign this box only if you are a US citizen. I am a citizen of the United States:

Signature:_____ Date:_____

Form is Double Sided – Complete Both Sides!

Client No. 2 Information (OPTIONAL)

A **spouse, romantic partner, or parent of your child who also wants their estate planning done at this clinic** may fill this section out if both people are comfortable with the other knowing what their wishes are as listed on this form.
Both will have to sign this form.

1. I am Client 1's: ☐ Spouse ☐Romantic Partner ☐Parent of Client 1's child

2. What is your (Client No. 2's) legal name as shown on your government ID:
   _____

3. What are your nicknames or other names used? (If you don't have any, write "*none"*)
   _____

4. Mailing Address:_____

5. Preferred Phone No. _____ Alternate Phone No. _____

6. Date of Birth: _____ Email: _____

7. If married (even if separated), what is your date of marriage? _____
   Legal name of spouse: _____

8. Marital Status (check all that apply):
   ☐ Single
   ☐ Married
   ☐ Divorced
   ☐ Separated
   ☐ Widowed, date of death of your spouse: _____

9. Have you ever made a will before? ☐ Yes ☐ No
   If yes, when did you sign that will? _____

10. Do you know where the original will is? ☐ Yes ☐ No
    (If yes, bring it to the clinic, if possible.)

11. Sign this box only if you are a US citizen. I am a citizen of the United States:

Signature:_____ Date: _____

Form is Double Sided – Complete Both Sides!

Family Information

1. If you are married, do you want your spouse to receive everything you own when you die?

   ☐ Yes ☐ No ☐ I am not married

2. If your spouse dies before you or you are unmarried, do you want all your children to receive everything you own in equal shares when you die?

   ☐ Yes ☐ No ☐ I do not have any children.

3. List ALL your CHILDREN, including stepchildren, those by a prior marriage, and those you have adopted (add additional pages if needed):

	Full Legal Name	**Date of Birth**	**Parents**	**If deceased, date of death**
1)	_____	_____	_____	_____
2)	_____	_____	_____	_____
3)	_____	_____	_____	_____
4)	_____	_____	_____	_____
5)	_____	_____	_____	_____
6)	_____	_____	_____	_____
7)	_____	_____	_____	_____

4. List the names of **any other people you would like to provide for in your will** and their relationship to you (i.e., grandchildren, nieces, nephews, etc.):

	Full Legal Name	**Date of Birth**	**Relationship**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____

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5. If you have a spouse or child who you **do not want to inherit from you**, please list them here:

	Full Legal Name	**Date of Birth**	**Relationship**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

Financial Information

1. Number of adults in your household: count only yourself, your spouse, or unmarried partner _____
   (Do NOT count other adults, like parents, adult children, or roommates)

2. Number of children under 18 in your household _____

3. Including the PFD, what is your gross income for all of your listed household members? (If you have no income, write zero) $ _____

4. What is the total estimated value of assets for your household? $_____

   (Assets include savings, investments, vacation/business property, etc. Do not include your home, Native allotments or other restricted property, any vehicles normally used for transportation)

6. Do you have any r**etirement accounts** (i.e. 401(k), IRA, 403(b), PERS, TERS, etc.)?
   ☐ Yes ☐ No

7. Do you have any shares of **Native Corporation Stock**?
   ☐ Yes ☐ No

8. Do you have a **stock will** for your Native Corporation stock that correctly shows your wishes?
   ☐ Yes ☐ No

9. Do you own any **restricted status land (a/k/a "allotments")?**
   ☐ Yes ☐ No

10. Do you own a house or other land that is not tribal land/restricted status?

☐ Yes (If yes, please send us the deeds or property tax statements or bring them to the clinic, if possible.)

☐ No

If you answered "Yes" to questions 9 or 10, please complete this:

Property 1 -Address_____

Property 1 -Legal Description_____

_____

Property 2 -Address_____

Property 2 -Legal Description_____

_____

11. Are any of the people you intend to name in your Will currently on **public assistance**, such as SSDI, food stamps (SNAP), or Medicaid?
☐ Yes ☐ No

12. Do you own a **Limited Entry Fishing Permit** or **IFQ**?
☐ Yes ☐ No

If yes, what is the permit number? _____

If you answered "Yes" to any of the questions above, please send copies of documents that show this with this completed form, or bring copies to the clinic for your appointment.

Agent Information

For all agents, list the legal name of the person you choose. List a first and second choice (in case the first choice person is dead or cannot serve). You may also want to list a third choice. For the power of attorney and health care directives, current mailing addresses and phone numbers are required. If there is not a second client who wants their estate plan done at this clinic, leave the "Client No. 2 Choices" blank.

1. **Personal Representative.** Sometimes also called an "executor," this is the person responsible for wrapping up your estate after your death. They will be in charge of selling and distributing your property, filing tax returns, and keeping everyone informed. Who would you like to name as your Personal Representative? List the LEGAL names of your first and second choices and you may choose to list a third choice.

Client No. 1 Choices:	Client No. 2 Choices (OPTIONAL):
1._____	_____
2._____	_____
3._____	_____

2. **Guardian:** If you have a minor child, or if you are the legal guardian of your adult child who has special needs, you can name successor guardians. These people would be responsible for caring for your child upon your death. Who do you want to name as guardians? (If you do not have children, just write "n/a")

Client No. 1 Choices:	Client No. 2 Choices (OPTIONAL):
1._____	_____
2._____	_____
3._____	_____

3. **Power of Attorney Agent**. This is the person responsible for making **financial decisions** for you if you are unable to handle those decisions yourself. If you choose to do so, they may even be able to help you handle such decisions *as soon as you sign the form*, even if you are still capable of doing things for yourself. Who would you like to name as your agent for your Power of Attorney? List the LEGAL names, addresses and phone numbers of your first and second choices. You may choose to also list a third choice.

Client No. 1 Choices:	Client No. 2 Choices (OPTIONAL):
1. Name:_____	**Name:** _____
Address: _____	Address:_____
_____	_____
Phone: _____	Phone:_____
2. Name:_____	**Name:** _____
Address: _____	Address:_____
_____	_____
Phone: _____	Phone:_____
3. Name: _____	**Name:** _____
Address: _____	Address:_____
_____	_____
Phone: _____	Phone:_____

4. **Health Care Agent**. Your health care agent is responsible for **health care decisions** for you if you can't make them for yourself, including end-of-life care decisions. Who would you like to name as your Health Care Agent? **List the LEGAL names, addresses and phone numbers of your first and second choices. You may choose to also list a third choice.**

Client No. 1:	Client No. 2:
1.Name:_____	**Name:** _____
Address: _____	Address:_____
_____	_____
Phone: _____	Phone:_____
2. Name:_____	**Name:** _____
Address: _____	Address:_____
_____	_____
Phone: _____	Phone:_____
3. Name: _____	**Name:** _____
Address: _____	Address:_____
_____	_____
Phone: _____	Phone:_____

Other Considerations

1. Do any of your beneficiaries (the people you are leaving things to in your Will) need assistance managing assets (health, disability, substance/alchohol abuse, debt problems, etc.)? If yes, please explain: _____
   _____
   _____
   _____
2. Do you have any legal issues we should be aware of? If yes, please explain:
   _____
   _____
   _____

Form is Double Sided – Complete Both Sides!

3. Are there any family dynamics or special facts that could affect your planning? If yes, please explain:

   _____

   _____

   _____

4. How did you hear about this legal clinic? _____

5. Additional notes for the attorney about your wishes: _____

   _____

   _____

   _____

   _____

   _____

   _____

I certify that the above information is true.

_____ _____

Date **Signature of Client 1**

_____ _____

Date **Signature of Client 2**

When done, email this form to lmckenna@alaskabar.org or keep a copy for yourself and mail it to:

Alaska Bar Association
840 K Street, Suite 100
Anchorage, AK 99501

We will contact you to schedule an appointment to have an attorney write up your documents for FREE on:

October 17, 2025
Elder Appreciation and Wills Clinic
Den'aina Convention Center in Anchorage
2nd floor, Tubughnenq' Room 5

You MUST bring a **government-issued photo ID** (like an Alaska Driver License) with you to your appointment or we cannot complete your documents.

Call us at (907) 272-7469 if you do not have this type of ID or if you have other questions.

If possible, **send COPIES of these documents** to the Alaska Bar Association with this form or bring them to your appointment on October 17, 2025:

1. Deeds or property tax statements for any real estate you own

2. Your current Will, power of attorney, and advance health care directive, if any

3. Documents relating to any Native allotments, limited entry fishing permits, and Native stock wills

Do NOT mail original documents. Documents provided will be shredded after the clinic.