INDIANAPOLIS BAR ASSOCIATION
Free Wills Application

Please note: Applications must be complete, with no fields left blank, in order to qualify.

Contact Information

☐ Mr. ☐ Mrs. ☐ Ms. ______________________________
First name Last

Spouse ______________________________
First name Last

Mailing Address ______________________________

City ____________________ State __________ ZIP __________

Phone ____________________

Birthdate __________ Age __________ Spouse's Age __________

Child's Name ____________________ Age __________

Child's Name ____________________ Age __________

Child's Name ____________________ Age __________

Prior to a consulation with an attorney, please consider specific people who you would like to name for the following roles:

Personal Representative: This person will be responsible for settling your affairs and distributing your assets to your designated beneficiaries.This person MUST be a resident of Indiana. The position can be two people, one of which can live out of state.

Guardian: This person will act in your place to protect, raise and insure the welfare of any minor children that may be alive at the time of your death.

Trustee: In the event that both spouses die while there are still surviving minor children, this person will be responsible to manage and safeguard the respective estates' assets for the benefit of the child or children. This person can be the same person or different person than the guardian.

Power of Attorney and/or Health Care Representative: Person(s) who, IF YOU BECOME INCAPACITATED and are officially declared by a medical professional to be incapacitated and your spouse is unable to act on your behalf or is no longer living, you desire to make financial and health care decisions and take actions on your behalf. You may name different people as your financial and the healthcare representative.

Also, for each of the above, you will need to name someone who will take over in the event the first person(s) you name is unable or unwilling to act.

Financial Information

Employed by ______________________ Position ______________________

Spouse Employed by ______________________ Position ______________________

Salary $______________________ Spouse Salary $______________________

Number of Dependents ________ Number of adults in household ________ Relationship ______________

Do you own your home? ☐ Yes ☐ No If YES, what is your monthly mortgage payment? $ ________

Estimated Value of Home $____________ Mortgage Balance $____________ (amount still owed to the bank)

Assets: Savings $__________ Stock/Bond/CDs $__________ Retirement $__________ Other $__________

Total Family Other Income:		Total Family Expenses:	
Social Security	$________________	Rent	$________________
Trusts	$________________	Food	$________________
Food Stamps	$________________	Utilities	$________________
Child Support	$________________	Child Support	$________________
AFDC	$________________		
TANF	$________________		

Automobile(s):

Year/Make/Model ______________________________________ Payments $ ____________

Year/Make/Model ______________________________________ Payments $ ____________

Long term or recurring medical and dental expenses which are not covered by insurance. Please give details of problem and expenses. ______________________________________

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Do you have any liens against your? ☐ Home ☐ Auto ☐ Medicaid

NOTICE: The information obtained on this form will be used to help determine if we can assist you with your legal needs. The information you provide is confidential, but it must be completed and truthful to the best of your knowledge. If you are accepted as a client, and if it is later determined that the information you have provided on this form is incomplete or untrue, your assigned attorney may immediately terminate his/her attorney/client relationship and will not provide you further counsel.

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