Jeremy A. Poll
Cancer Families
Will Clinic

CLIENT APPLICATION

INTRODUCTION AND OVERVIEW

The Jeremy A. Poll Cancer Families Will Clinic provides free estate planning services for individuals and couples coping with a recent cancer diagnosis. The Clinic is managed by Good Faith Legal, P.S., and operated through a network of volunteer attorneys with the assistance of volunteer notaries, witnesses, and document preparers. Clients selected for the Poll Clinic will receive the following services at absolutely no cost:

- Initial consultation;
- Review of current estate documents (if applicable);
- Preparation of basic estate plan for an individual or couple, including will, general durable power of attorney, healthcare power of attorney and healthcare directive, and HIPAA authorization; and
- Execution ceremony and recording of wills (if applicable).

When a trust is desired as part of an estate plan, services will be billed hourly at a discounted rate determined by the Poll Clinic. Your attorney will go over the hourly rate with you and provide an estimate of the anticipated costs.

HOW IT WORKS

When a client qualifies for the Poll Clinic, he or she will be referred to one of our volunteer attorneys, who will assist the client, and his or her spouse as applicable, with the preparation of a basic estate plan. Our clients' positive experience is our top priority, so we screen all volunteers to ensure that everyone involved with the Poll Clinic fosters the spirit of kindness and the standard of excellence that we stand for.

Our volunteer attorneys may work entirely from their own offices, or may utilize the offices of Good Faith Legal, P.S. for client meetings and estate document execution ceremonies. Poll Clinic staff do not oversee the work of volunteer attorneys, so all questions related to the estate plan should be addressed directly to the attorney. However, we welcome client feedback about the assigned attorney and other volunteers, as well as questions or comments about Clinic operations, all of which can be sent to the Poll Clinic Administrator, Amy Blue, at administrator@pollclinic.com.

ELIGIBILITY AND THE APPLICATION PROCESS

We are honored to assist families through the Poll Clinic, but are limited in the number of clients we can accept each month. From time to time, approved applicants may be placed on a waiting list, and will be kept updated on the progress of their application. To be eligible to receive estate planning services through the Poll Clinic, applicant families will have:

- A parent between the ages of 20 and 55 who has been diagnosed with cancer within the last six months;
- At least one child under the age of 18;
- Permanent residency in Washington State; and
- Combined annual income less than $200,000.

All applicants must complete and return the attached application. We will notify you via email when your application is received. Please allow up to two weeks to process the application. Qualifying clients will receive a letter of acceptance and an email introduction to the assigned volunteer attorney. If we determine an applicant does not qualify, we will notify the applicant with our regrets as soon as possible.

If you are interested in receiving services through the Poll Clinic, please complete pages 2–5 and return your completed application to administrator@pollclinic.com, or by mail to Poll Clinic, c/o Good Faith Legal P.S., 26837 Maple Valley Hwy Ste. 103, Maple Valley, WA 98038.

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SECTION 1: APPLICANT INFORMATION			
Last First MI			Date of birth:
Email:			Primary phone: ❑ cell ❑ home ❑ work
Street address	City	ST	ZIP
Current or most recent employer:	Salary or wage:	Dates of employment:	
Favorite pastime, hobby, area of interest, or guilty pleasure:			

Preparing my will makes me feel: ❑ reassured ❑ responsible ❑ anxious ❑ scared ❑ sad

My physical status to assist in preparing my will is: ❑ pretty good ❑ good ❑ adequate ❑ weak

My emotional status to assist in preparing my will is: ❑ pretty good ❑ good ❑ adequate ❑ weak

Accommodations that would help me participate in the preparation of my will include (check all that apply):

❑ in-home consultations, including initial meeting, in-person document review, and will execution ceremony
❑ avoiding small talk about my diagnosis or medical status
❑ candid discussion about my diagnosis or medical status
❑ as much email communication as possible, rather than office visits or phone calls
❑ routing questions and concerns through my spouse or other designated family member
❑ scheduling appointments during evenings, weekends, early mornings, or specific days, as follows:

_____

❑ beginning the process after a certain date, or completing the process before a certain date, as indicated below, due to treatment schedules, family vacations, or work obligations:

_____

_____

❑ other:

_____

_____

_____

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SECTION 2: FAMILY INFORMATION		
Spouse's name:	Date of birth:	Phone or email:
Name (First & Last)	**Gender**	**Date of birth:**
Child:	❑ M ❑ F	
Child:	❑ M ❑ F	
Child:	❑ M ❑ F	
Child:	❑ M ❑ F	
Child:	❑ M ❑ F	
Child:	❑ M ❑ F	

Do any of the children listed above have another legal parent other than you and your spouse? ❑ no ❑ yes
If yes, please provide the name, phone number, and residence of the other parent:

Parent Name	Phone Number	Residence (City, ST)
Parent of:		
Parent Name	Phone Number	Residence (City, ST)
Parent of:		

Please list any other close family or friends you would like us to be aware of and potentially in contact with:

Name:	Phone or email:	Relationship:
Name:	Phone or email:	Relationship:

SECTION 3: FINANCIAL INFORMATION		
Spouse's employer:	Spouse's salary or wage:	Dates of employment:

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Do you or your spouse have other sources of regular income? ❑ no ❑ yes
If yes, please indicate as follows:

Source or type of additional income	Amount (monthly)
Source or type of additional income	Amount (monthly)

Combined annual household income:	Household status: ❑ own ❑ rent ❑ other

Please indicate any regular expenses for child support, spousal maintenance, or other court-ordered payments:

_____

_____

_____

_____

SECTION 4: DIAGNOSIS INFORMATION*

Please have your oncologist or physician complete this section and sign where indicated below.

Diagnosis:	Date of diagnosis:	Prognosis:
Treating hospital or clinic:		Provider name:
Date and purpose of last appointment:		Provider phone:

By my signature below, I affirm that the information provided above is true and accurate to the best of my knowledge. The applicant is my patient at the indicated medical facility, and is undergoing treatment or supervision for cancer. I am signing this form for informational purposes only, relevant to this application for the Jeremy A. Poll Cancer Families Will Clinic ("Poll Clinic"), and nothing on this form shall be construed as a waiver of doctor-patient confidentiality; provided, that I may be required to verify the information provided in this Section 4 to a representative of the Poll Clinic in order to qualify the applicant for services from the Poll Clinic.

_____ _____
Signature of medical provider Date

Please be aware that we sometimes find it necessary to verify diagnoses in order to protect our clients from the type of people who would deceitfully and disrespectfully attempt to take advantage of Poll Clinic services.

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SECTION 5: AUTHORIZATION

I am submitting this application to receive *pro bono* estate planning services through the Jeremy A. Poll Cancer Families Will Clinic ("Poll Clinic"). I hereby authorize the Poll Clinic to contact my medical provider to verify the information provided in Section 4 above, and authorize the named medical provider, or his or her representative, to disclose such information as is necessary to verify the information provided on this application. I further authorize the Poll Clinic to contact and share information with ❑ my spouse or ❑ _____, whose name and contact information are provided in Section 2 above, regarding this application and any services I receive through the Poll Clinic.

_____ _____
Applicant signature Date

Lime green is the awareness ribbon for Non-Hodgkin's Lymphoma.

POLL CLINIC USE ONLY:

Date application received:	Client ID:
Diagnosis verified? ❑ no ❑ yes, on: _____	Spoke with:
Criteria: ❑ age 20–55 ❑ WA resident ❑ diagnosis < 6 mo ❑ income < $200,000 ❑ children under 18	Accommodations requested? ❑ no ❑ yes Follow-up needed? ❑ no ❑ yes

Approved & assigned:	Approved & waitlisted:	Regretfully declined: