

**LONG TERM CARE PLANNING QUESTIONNAIRE
(SINGLE INDIVIDUAL)**

Thank you for selecting Estate Planning & Elder Law Services, P.C. to assist you with your long term care planning needs. To maximize the effectiveness and efficiency of our first meeting together, we ask that you provide as much of the information sought in this form as possible. Your accuracy and completeness in responding will help us to best represent you in this matter. Please bring this information with you to our initial appointment.

A. PERSONAL DATA

Residence Information

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Other states in which you have resided: _____

Biographical & Contact Information

Full Name: _____

Birth Date: _____

Social Security No.: _____

U.S. Citizen? ___ Yes ___ No

Home Phone: _____

Home E-mail: _____

Work Phone: _____

Work E-mail: _____

Work Fax: _____

Cell Phone: _____

Communicating with you: Check the box above for your preferred mode of communication.

B. HOW DID YOU HEAR ABOUT US?

Seminar/Community Ed. _____(location) Postcard

Referred by: _____

Yellow pages

Search Engine: Google MSN Yahoo! Other _____

Have you visited our website www.formyplan.com? ___ Yes ___ No Please provide any suggestions. _____

C. CHILDREN & MARRIAGE(S) (include adopted children)

Child's Name, Address & Phone #	Date of Birth	Name of Other Parent	Parent that Child Lives With	# of Children (i.e., your grandchildren)

Have you ever been married before? ___ Yes ___ No

If "yes" to the previous question, are you divorced from your former spouse(s), or is/are your former spouse(s) deceased? **Provide name(s) of former spouse(s) and date(s) of divorce(s) or death(s):**

Are all of your children in good health? ___ Yes ___ No

(If no, please describe the issue(s) and for which child(ren) such issue(s) apply)

Are any of your children blind? ___ Yes ___ No

(If yes, which child(ren)?) _____

Are any of your children disabled? ___ Yes ___ No
(If yes, please describe the disability and the child(ren) effected by such disability)

Are any of your children receiving SSI, SSD or other government benefits? ___ Yes ___ No
(If yes, please list the benefits and child(ren) receiving them)

Are any of your children deceased? ___ Yes ___ No
(If yes, please list the name(s) of the deceased child(ren) and the name(s) of their living child(ren), if any)

D. EXTENDED FAMILY

Parents

	<u>Name</u>	<u>Age</u>	<u>Date of Death</u>
Father:	_____	_____	_____
Mother:	_____	_____	_____

Siblings (attach separate sheet if more than 2 siblings)

<u>Name</u>	<u>Age</u>	<u>Date of Death</u>	<u># of Children</u>
_____	_____	_____	_____
_____	_____	_____	_____

E. MEDICAL HISTORY (Please indicate the prognosis for all of the applicable conditions)

1. Medical Conditions

<u>Condition</u>	<u>Prognosis</u>
<i>Dementia</i>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<i>Alzheimer's</i>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<i>Parkinson's</i>	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Cancer Good Fair Poor

Stroke Good Fair Poor

Heart Attack Good Fair Poor

Heart Issues Good Fair Poor

ALS Good Fair Poor

Other Good Fair Poor

Described Your Overall Condition: _____

2. Level of Dependence (Indicate the level of dependence for the activities below.)

<u>Activity</u>	<u>Dependence</u>		
<i>Feeding</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete
<i>Dressing</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete
<i>Bathing</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete
<i>Transferring</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete
<i>Toileting</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete
<i>Medications</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete
<i>Finances</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete
<i>Transport</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete

3. Level of Care Needed

Independent Senior Apt. Assisted Living Nursing Home

Determined by: Husband Wife Family Caregiver Physician

Goal/Desires for Care Setting: _____

4. **Physician(s)**

Primary Physician _____ Phone #: _____

Specialist _____ Phone #: _____

E. RESIDENCE INFORMATION

Please identify all recent hospital admissions and/or periods of residence in a nursing home.

Name of Hospital/Facility _____ Phone #: _____

Dates of Admission/Residence: From _____ To _____

Name of Hospital/Facility _____ Phone #: _____

Dates of Admission/Residence: From _____ To _____

Describe your living and care situation over last the last twelve months:

F. MEDICAL & LONG TERM CARE INSURANCE

Provide the information requested below for **all** health related insurance coverage, including: Medicare, Medicare Supplements, Medicare Part D, Medicare Advantage Plans, “privately paid” health insurance and/or prescription drug coverage, VA coverage, vision and dental coverage, and long term care coverage.

<u>Policy Type</u>	<u>Provider</u>	<u>Premium</u>
Medicare	_____ N/A _____	\$ _____ /mn
_____	_____	\$ _____ /mn
_____	_____	\$ _____ /mn
_____	_____	\$ _____ /mn

If the premiums for any of the above coverages are automatically withheld from a pension or other income, please identify from where: _____

G. MILITARY SERVICE HISTORY

Your Information

Veteran ___ Yes ___ No
 Period of Service _____ - _____
 Wartime Service ___ Yes ___ No
 Service Disability ___ Yes ___ No

Deceased Spouse's Information

Veteran? ___ Yes ___ No
 Period of Service _____ - _____
 Wartime Service ___ Yes ___ No
 Service Disability ___ Yes ___ No

H. FINANCIAL SUMMARY

1. Assets

Current Value

		<u>Joint</u>	<u>With Whom</u>
Checking Accts. (# of accounts: _____)	\$ _____	<input type="checkbox"/>	_____
Savings Accts. (# of accounts: _____)	\$ _____	<input type="checkbox"/>	_____
Real Estate (residence)	\$ _____	<input type="checkbox"/>	_____
Real Estate (other)	\$ _____	<input type="checkbox"/>	_____
CD's (# of accounts: _____)	\$ _____	<input type="checkbox"/>	_____
Money Mkt. Accts. (# of accounts: _____)	\$ _____	<input type="checkbox"/>	_____
Stocks	\$ _____	<input type="checkbox"/>	_____
Bonds	\$ _____	<input type="checkbox"/>	_____
Mutual Funds	\$ _____	<input type="checkbox"/>	_____
Notes and Mortgages Receivable	\$ _____	<input type="checkbox"/>	_____
Business Interests	\$ _____	<input type="checkbox"/>	_____
Expected Inheritances/Settlements	\$ _____		
Motor Vehicles (# of vehicles: _____)	\$ _____		
Jewelry & Collections	\$ _____		
Non-IRA Qualified Retirement Plans	\$ _____		

IRAs \$ _____

Annuities \$ _____

Other Assets \$ _____

2. Life Insurance (Identify all policies owned by either spouse.)

<u>Insured</u>	<u>Company/ Policy #</u>	<u>Face Value*</u>	<u>Cash Value</u>
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

* The face value is also called the “death benefit” payable under the policy.

3. Liabilities

<u>Current Balance</u>	<u>Joint</u>	<u>With Whom</u>
Mortgages/Home Equity Loans \$ _____	<input type="checkbox"/>	_____
Other Loans Payable \$ _____	<input type="checkbox"/>	_____
Credit Card Debt \$ _____	<input type="checkbox"/>	_____
Other Miscellaneous Debt \$ _____	<input type="checkbox"/>	_____

I. MONTHLY INCOME

Social Security Benefits (Gross) \$ _____

Retirement Benefits (Gross) \$ _____

Veterans Benefits (Gross) \$ _____

Disability Benefits \$ _____

Rental Income \$ _____

Interest/Dividend Income \$ _____

Annuity \$ _____

Other Income _____ \$ _____

J. SHELTER EXPENSES

Rent/Mortgage \$_____ Month Year
Property Taxes \$_____ Month Year
Water/Sewer \$_____ Month Year
Utilities (Heat, Electric & Telephone) \$_____ Month Year
Insurance (Renter's/Homeowners) \$_____ Month Year
Association Fees \$_____ Month Year

K. NON-SHELTER EXPENSES

Medical/Prescriptions \$_____ Month Year
Clothing \$_____ Month Year
Auto Insurance/Transportation \$_____ Month Year
Home Maintenance \$_____ Month Year
Life Insurance Premiums \$_____ Month Year
Federal & State Income Taxes \$_____ Month Year
Other _____ \$_____ Month Year

L. GIFTS

Have you made any gifts to an individual, group of individuals, charity or a trust within the last 60 months (5 years)? ___ Yes ___ No

If yes, please provide the information requested below for each gift:

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Note: If additional gifts, please attach separate sheet.

Have you ever filed a Federal Gift Tax Return relating to any gifts? ___ Yes ___ No

Have you reported any gifts as deductions on your income tax returns? ___ Yes ___ No

M. ESTATE PLANNING/LEGAL INFORMATION

Which, if any, estate planning document(s) do you have in place?

Will(s) Trust(s) Medical Power(s) of Attorney Financial Power(s) of Attorney

Decision Makers Named: _____

List the names and dates of any presently court appointed guardian(s) or conservator(s):

Guardian _____ Date Appointed _____

Conservator _____ Date Appointed _____

Explain any pending lawsuits or other legal issues that we should be aware of:

N. DOCUMENT CHECKLIST (Please bring these documents to the initial meeting.)

- Recent account statements for all assets
- Recent statements for all life insurance policies
- Deed(s), land contracts, mortgages, notes and recent tax statements for all real estate
- Motor vehicle titles
- Estate planning documents (i.e. – wills, trusts, powers of attorney, etc)
- Letters of Authority (For court appointed guardians and/or conservators)
- “Your New Benefit Amount” statement from Social Security for current year
- Proof of other income and deductions
- Private health insurance coverage policies and recent statement
- Proof of identification, including drivers license, SS card and birth certificate
- Proof of health status of person in need of long term care, including places of treatment, dates and provider names
- Long term care coverage policies
- Proof of veterans status and any disability rating information
- Proof of shelter expenses (i.e. - expenses such as mortgage, real property taxes, insurance, assessments, utilities) with regard to your home/apartment/condo
- Proof of residence in nursing home (i.e. - contract, bills, etc)
- Divorce judgments

O. CERTIFICATION

The information contained in this Estate Planning Questionnaire is accurate and complete to the best of my knowledge, information, and belief, and I understand that the law firm and its

individual lawyers will rely upon this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature

Date