

**LONG TERM CARE PLANNING QUESTIONNAIRE
(MARRIED)**

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: _____

Husband's Information

Wife's Information

Full Name: _____ Full Name: _____

Birth Date: _____ Birth Date: _____

Social Security No.: _____ Social Security No.: _____

U.S. Citizen? ___ Yes ___ No U.S. Citizen? ___ Yes ___ No

Home Phone: _____ Home Fax: _____

Home E-mail: _____ Home E-mail: _____

Work Phone: _____ Work Phone: _____

Work E-mail: _____ Work E-mail: _____

Work Fax: _____ Work Fax: _____

Cell Phone: _____ 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	From Previous Marriage (Husband)	From Previous Marriage (Wife)	# of Children (i.e., your grandchildren)

Date of Present Marriage: ____/____/____

Have either of 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):**

Does the Husband have any children from a previous marriage? ___ Yes ___ No
(If yes, include name(s) above, and check the "From Previous Marriage" box)

Does the Wife have any children from a previous marriage? ___ Yes ___ No
(If yes, include name(s) above, and check the "From Previous Marriage" box)

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

Husband's Parents

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

Wife's Parents

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

Husband's Siblings (attach separate sheet if more than 2 siblings)

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

Wife's 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 (Husband)</u>			<u>Prognosis (Wife)</u>		
<i>Dementia</i>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<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	<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	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<i>Cancer</i>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<i>Stroke</i>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<i>Heart Attack</i>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<i>Heart Issues</i>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<i>ALS</i>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<i>Other</i>	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

Described Husband's & Wife's Overall Condition: _____

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

<u>Activity</u>	<u>Dependence (Husband)</u>			<u>Dependence (Wife)</u>		
<i>Feeding</i>	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete	<input type="checkbox"/> None	<input type="checkbox"/> Partial	<input type="checkbox"/> Complete

Dressing None Partial Complete None Partial Complete
Bathing None Partial Complete None Partial Complete
Transferring None Partial Complete None Partial Complete
Toileting None Partial Complete None Partial Complete
Medications None Partial Complete None Partial Complete
Finances None Partial Complete None Partial Complete
Transport None Partial Complete None Partial Complete

3. Level of Care Needed

Husband: Independent Senior Apt. Assisted Living Nursing Home

Wife: Independent Senior Apt. Assisted Living Nursing Home

Determined by: Husband Wife Family Caregiver Physician

Goal/Desires for Care Setting: _____

4. Physician(s)

Primary Physician (Husband) _____ Phone #: _____

Specialist (Husband) _____ Phone #: _____

Primary Physician (Wife) _____ Phone #: _____

Specialist (Wife) _____ Phone #: _____

E. RESIDENCE INFORMATION

1. Husband

Has the husband been admitted to a hospital and/or resided in a nursing home, or combination of both, for **30 or more** consecutive days? ___ Yes ___ No If yes, please provide the name(s) and date(s) of admission or residence.

Name of Hospital/Facility _____ Phone #: _____

Dates of Admission/Residence: From _____ To _____

Name of Hospital/Facility _____ Phone #: _____

Dates of Admission/Residence: From _____ To _____

Prior to this period, where did the husband live? _____

2. Wife

Has the wife been admitted to a hospital and/or resided in a nursing home, or combination of both, for **30 or more** consecutive days? ___ Yes ___ No If yes, please provide the name(s) and date(s) of admission or residence.

Name of Hospital/Facility _____ Phone #: _____

Dates of Admission/Residence: From _____ To _____

Name of Hospital/Facility _____ Phone #: _____

Dates of Admission/Residence: From _____ To _____

Prior to this period, where did the wife live? _____

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 for both spouses, 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>Owner</u>	<u>Policy Type</u>	<u>Provider</u>	<u>Premium</u>	<u>Paid For By</u>
<input type="checkbox"/> H <input type="checkbox"/> W	Medicare	_____ N/A _____	\$ _____ /mn	N/A
<input type="checkbox"/> H <input type="checkbox"/> W	Medicare	_____ N/A _____	\$ _____ /mn	N/A
<input type="checkbox"/> H <input type="checkbox"/> W	_____	_____	\$ _____ /mn	<input type="checkbox"/> H <input type="checkbox"/> W
<input type="checkbox"/> H <input type="checkbox"/> W	_____	_____	\$ _____ /mn	<input type="checkbox"/> H <input type="checkbox"/> W

H W _____ \$ _____/mn H W
 H W _____ \$ _____/mn H W
 H W _____ \$ _____/mn H W
 H W _____ \$ _____/mn H W

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

Husband's Information

Wife's Information

Veteran ___ Yes ___ No

Veteran? ___ Yes ___ No

Period of Service _____ - _____

Period of Service _____ - _____

Wartime Service ___ Yes ___ No

Wartime Service ___ Yes ___ No

Service Disability ___ Yes ___ No

Service Disability ___ Yes ___ No

H. FINANCIAL SUMMARY

1. Assets

	<u>Husband</u>	<u>Wife</u>	<u>Joint</u>
Checking Accts. (# of accounts: _____)	\$ _____	\$ _____	\$ _____
Savings Accts. (# of accounts: _____)	\$ _____	\$ _____	\$ _____
CD's (# of accounts: _____)	\$ _____	\$ _____	\$ _____
Money Mkt. Accts. (# of accounts: _____)	\$ _____	\$ _____	\$ _____
Real Estate (residence)	\$ _____	\$ _____	\$ _____
Real Estate (other)	\$ _____	\$ _____	\$ _____
Stocks	\$ _____	\$ _____	\$ _____
Bonds	\$ _____	\$ _____	\$ _____
Mutual Funds	\$ _____	\$ _____	\$ _____

Notes and Mortgages Receivable	\$ _____	\$ _____	\$ _____
Business Interests	\$ _____	\$ _____	\$ _____
Expected Inheritances/Settlements	\$ _____	\$ _____	\$ _____
Motor Vehicles (# of vehicles: _____)	\$ _____	\$ _____	\$ _____
Jewelry & Collections	\$ _____	\$ _____	\$ _____
Non-IRA Qualified Retirement Plans	\$ _____	\$ _____	\$ _____
IRAs	\$ _____	\$ _____	\$ _____
Annuities	\$ _____	\$ _____	\$ _____
Nursing Home Patient Trust Account	\$ _____	\$ _____	\$ _____
Mortgages/Loans Owed to You	\$ _____	\$ _____	\$ _____
Funeral Contracts	\$ _____	\$ _____	\$ _____
Burial plots, markers, and headstones	\$ _____	\$ _____	\$ _____
Other Assets	\$ _____	\$ _____	\$ _____

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

<u>Owner</u>	<u>Insured</u>	<u>Company/Policy #</u>	<u>Face Value*</u>	<u>Cash Value</u>
<input type="checkbox"/> H <input type="checkbox"/> W	_____	_____	\$ _____	\$ _____
<input type="checkbox"/> H <input type="checkbox"/> W	_____	_____	\$ _____	\$ _____
<input type="checkbox"/> H <input type="checkbox"/> W	_____	_____	\$ _____	\$ _____
<input type="checkbox"/> H <input type="checkbox"/> W	_____	_____	\$ _____	\$ _____

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

3. Liabilities

	<u>Husband</u>	<u>Wife</u>	<u>Joint</u>
Mortgages/Home Equity Loan(s)	\$ _____	\$ _____	\$ _____
Other Loans Payable	\$ _____	\$ _____	\$ _____

Credit Card Debt \$ _____ \$ _____ \$ _____

Other Miscellaneous Debt \$ _____ \$ _____ \$ _____

I. MONTHLY INCOME

<u>Source</u>	<u>Husband</u>	<u>Wife</u>	<u>Joint</u>
Social Security Benefits (Gross)	\$ _____	\$ _____	
Retirement Benefits (Gross)	\$ _____	\$ _____	
Veterans Benefits (Gross)	\$ _____	\$ _____	
Disability Benefits	\$ _____	\$ _____	
Rental Income	\$ _____	\$ _____	\$ _____
Interest/Dividend Income	\$ _____	\$ _____	\$ _____
Annuity	\$ _____	\$ _____	\$ _____
Other Income _____	\$ _____	\$ _____	\$ _____

J. SHELTER EXPENSES Provide the following information for your *primary place of residence*.

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 (Husband) \$ _____ Month Year

Medical/Prescriptions (Wife) \$ _____ 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):

	<u>Husband</u>	<u>Wife</u>	<u>Date Appointed</u>
Guardian	_____	_____	_____
Conservator	_____	_____	_____

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 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)

O. CERTIFICATION

The information contained in this Long Term Care Planning Questionnaire is accurate and complete to the best of our knowledge, information, and belief, and we understand that the law firm and its individual lawyers will rely upon this information. We understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Husband’s Signature

Date

Wife’s Signature

Date