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

	Name	Age	Date of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____

Siblings (attach separate sheet if more than 2 siblings)

Name	Age	Date of Death	# of Children
_____	_____	_____	_____
_____	_____	_____	_____

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

1. Medical Conditions

Condition	Prognosis
Dementia	□ Good □ Fair □ Poor
Alzheimer's	□ Good □ Fair □ Poor
Parkinson's	□ Good □ Fair □ 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. <u>Level of Dependence</u> (Indicate the level of dependence for the activities below.)

<u>Activity</u>	**<u>Dependence</u>**
Feeding	☐ None ☐ Partial ☐ Complete
Dressing	☐ None ☐ Partial ☐ Complete
Bathing	☐ None ☐ Partial ☐ Complete
Transferring	☐ None ☐ Partial ☐ Complete
Toileting	☐ None ☐ Partial ☐ Complete
Medications	☐ None ☐ Partial ☐ Complete
Finances	☐ None ☐ Partial ☐ Complete
Transport	☐ None ☐ Partial ☐ Complete

3. <u>Level of Care Needed</u>

☐ 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.

Policy Type	**Provider**	**Premium**
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	**Deceased Spouse'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

Current Value		**Joint**	**With Whom**
Checking Accts. (# of accounts: ____)	$_____	□	_____
Savings Accts. (# of accounts: ____)	$_____	□	_____
Real Estate (residence)	$_____	□	_____
Real Estate (other)	$_____	□	_____
CD's (# of accounts: ____)	$_____	□	_____
Money Mkt. Accts. (# of accounts: ____)	$_____	□	_____
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 $_____

Other Assets $_____

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

Insured	**Company/ Policy #**	**Face Value***	**Cash Value**
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____

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

3. Liabilities

Current Balance		**Joint**	**With Whom**
Mortgages/Home Equity Loans	$_____	□	_____
Other Loans Payable	$_____	□	_____
Credit Card Debt	$_____	□	_____
Other Miscellaneous Debt	$_____	□	_____

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