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. <u>CHILDREN & MARRIAGE(S)</u> (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

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

Wife's Parents

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

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

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

_____ _____ _____ _____

Wife's 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 (Husband)**			**Prognosis (Wife)**		
Dementia	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
Alzheimer's	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
Parkinson's	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
Cancer	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
Stroke	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
Heart Attack	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
Heart Issues	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
ALS	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor
Other	☐ Good	☐ Fair	☐ Poor	☐ Good	☐ Fair	☐ Poor

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

_____

_____

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

Activity	**Dependence (Husband)**			**Dependence (Wife)**		
Feeding	☐ None	☐ Partial	☐ Complete	☐ None	☐ Partial	☐ 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.

Owner	Policy Type	Provider	Premium	Paid For By
☐ H ☐ W	Medicare	N/A	$ /mn	N/A
☐ H ☐ W	Medicare	N/A	$ /mn	N/A
☐ H ☐ W	_____	_____	$ /mn	☐ H ☐ W
☐ H ☐ W	_____	_____	$ /mn	☐ H ☐ 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

	Husband	**Wife**	**Joint**
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.)

Owner	**Insured**	**Company/Policy #**	**Face Value***	**Cash Value**
☐ H ☐ W	_____	_____	$_____	$_____
☐ H ☐ W	_____	_____	$_____	$_____
☐ H ☐ W	_____	_____	$_____	$_____
☐ H ☐ W	_____	_____	$_____	$_____

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

3. Liabilities

	Husband	**Wife**	**Joint**
Mortgages/Home Equity Loan(s)	$_____	$_____	$_____
Other Loans Payable	$_____	$_____	$_____

Credit Card Debt	$_____	$_____	$_____
Other Miscellaneous Debt	$_____	$_____	$_____

I. MONTHLY INCOME

Source	**Husband**	**Wife**	**Joint**
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):

	Husband	Wife	Date Appointed
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