

Appointment date and time: _____

LONG TERM CARE PLANNING QUESTIONNAIRE

Please complete the following questionnaire to the best of your ability. This information is most helpful to us so that we may properly plan for you and it will be held in the strictest confidence. We will review this information at our meeting. The client is the person for whom planning is being implemented.

DO NOT BE UPSET IS YOU CANNOT COMPLETE ALL OF THE QUESTIONS.

PERSONAL INFORMATION

Name of Client: _____ Date of Birth _____ Soc. Sec. # _____

Spouse: _____

Address: _____

Telephone: Home: _____ Cell: _____
Business: _____ Email: _____

Contact Person (if not client): _____
Name Relationship to Client

Address: _____

Telephone: Home: _____ Cell: _____
Business: _____ Email: _____

Client's Objective: _____

MARITAL INFORMATION

Have you been married previously? _____

If yes, please provide prior spouse's name and date of death or divorce: _____

CHILDREN

Children of present marriage (living and deceased). Indicate if deceased by putting "D" and give date of death next to name.

<u>Name</u>	<u>Address</u>	<u>Phone #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Client:
Children of a prior marriage:**

<u>Name</u>	<u>Address</u>	<u>Phone #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Spouse:
Children of a prior marriage:**

<u>Name</u>	<u>Address</u>	<u>Phone #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list name and relationships of persons who are dependent on you for support:

GENERAL INFORMATION

	Client	Spouse
	Yes/No	Yes/No
Do you receive Social Security?	_____	_____
If yes, is the check directly deposited?	_____	_____
Have you been appointed as a fiduciary (executor, Trustee, attorney-in-fact, etc.) under any legal Documents?	_____	_____
Are you involved in a lawsuit? If yes, please explain:	_____	_____

Do any family members require special attention? For example, health, physical, mental, financial status, special and/or individual needs. If yes, please explain:	_____	_____

Do any of your children receive Social Security Disability?	_____	_____
Do any of your children receive Supplemental Security Income (SSI)?	_____	_____
Is anyone at risk of becoming seriously ill or disabled (due to a medical condition or family history)?	_____	_____

HEALTH CARE INFORMATION

	Client	Spouse
	Yes/No	Yes/No
Do you have or receive the following:		
Medicare Part A___ Part B___ Part C___	_____	_____
Supplemental insurance If yes, name: _____	_____	_____
Long Term Care insurance If yes, name: _____	_____	_____

Medicaid benefits

Veterans benefits

Are you a veteran?

DOCUMENTS

Client Spouse
Yes/No

Please indicate if you have any of the following:

Will?

If yes, date of Will? _____

Durable Power of Attorney?

Health Care Power of Attorney?

Living Will?

Trust?

If yes, indicate Irrevocable or Revocable

Pre-paid funeral/burial plan?

PROFESSIONAL ADVISORS

Tax Preparer/Accountant:

Name: _____

Company: _____

Address: _____

Telephone: _____

Financial Advisor:

Name: _____

Company: _____

Address: _____

Telephone: _____

INCOME AND EXPENSES

Please list your estimated monthly income and health care expenses.

Monthly Income

<u>Income</u>	<u>Client</u>	<u>Spouse</u>	<u>Total</u>
Social Security	\$ _____	\$ _____	\$ _____
Interest	_____	_____	_____
Dividends	_____	_____	_____
Pension Benefits	_____	_____	_____
IRA Benefits	_____	_____	_____
Rental Income	_____	_____	_____
Other Taxable Income	_____	_____	_____
Other Non-Taxable Income	_____	_____	_____
Total Income:	\$ _____	\$ _____	\$ _____

Monthly Health Care Expenses

	<u>Client</u>	<u>Spouse</u>	<u>Total</u>
Home care	_____	_____	_____
Insurance Premiums	_____	_____	_____
Prescriptions	_____	_____	_____
Nursing Home	_____	_____	_____
Other	_____	_____	_____
Total Expenses:	\$ _____	\$ _____	\$ _____

ASSETS

1. Real Estate

Owner: _____

Location: _____

Estimated Value: _____ Mortgage Balance: _____

Owner: _____

Location: _____

Estimated Value: _____ Mortgage Balance: _____

Do you receive a senior citizen's exemption on your primary residence? () Yes () No

2. Cash, Bank Accounts and CD's

	<u>Owner</u>	<u>Name of Bank</u>	<u>Amount</u>
Cash	_____	_____	_____
Checking	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Savings/ Money Market	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
CD's	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

3. Stocks and Bonds

<u>Owner</u>	<u>Company</u>	<u>Number of Shares</u>	<u>Amount</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Brokerage Accounts

<u>Owner</u>	<u>Name of Company</u>	<u>Amount</u>

Savings Bonds

<u>Owner</u>	<u>Type</u>	<u>Number of Bonds</u>	<u>Amount</u>

4. Life Insurance

<u>Owner</u>	<u>Company</u>	<u>Face Amount</u>	<u>Cash Amount</u>	<u>Insured</u>	<u>Beneficiary</u>

5. Retirement Benefits

Pension

<u>Owner</u>	<u>Beneficiary</u>	<u>Principal Amount</u>

401(K) Plan

<u>Owner</u>	<u>Beneficiary</u>	<u>Principal Amount</u>

LIABILITIES

Debts owned by you or your spouse, contractual and leasehold obligations, pending lawsuits and claims, etc.

1. Mortgage

	<u>Name of Debtor</u>	<u>Amount</u>
Home Mortgage	_____	_____
Other Mortgage	_____	_____

2. General Debts

Credit Cards _____

Notes and accounts payable by you _____

Unsecured Promissory notes _____

Other _____

GIFTS YOU HAVE MADE

Have you or your spouse made any gifts in excess of \$11,000 per year per recipient? If yes provide the following information as well as a copy of any filed gift tax returns.

<u>Donor</u>	<u>Recipient</u>	<u>Date Given</u>	<u>Amount</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____