



CONFIDENTIAL
LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

DATED: _____

I. CLIENT & FAMILY

Client Name: _____

Address: _____
_____ US Citizen: Yes ___ No ___

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____ Date of Marriage: _____

Employer: _____ Annual Income: _____

Spouse/Significant Other Name: _____

Address: _____
_____ US Citizen: Yes ___ No ___

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____ Date of Marriage: _____

Employer: _____ Annual Income: _____

Client (Prior Marriages)

Name of Former Spouse: _____ Date of Marriage: _____

Place of Marriage: _____ Year Terminated: _____

Spouse (Prior Marriages)

Name of Former Spouse: _____ Date of Marriage: _____

Place of Marriage: _____ Year Terminated: _____

Have you ever resided in a "community property" state, like Florida? Yes No

CHILDREN, GRANDCHILDREN AND/OR RELATIVES

1. Name: _____ **Relation:** _____

Address: _____

_____ US Citizen: Yes ___ No ___

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

2. Name: _____ **Relation:** _____

Address: _____

_____ US Citizen: Yes ___ No ___

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

3. Name: _____ **Relation:** _____

Address: _____

_____ US Citizen: Yes ___ No ___

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

4. Name: _____ **Relation:** _____

Address: _____

_____ US Citizen: Yes ___ No ___

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

5. Name: _____ **Relation:** _____

Address: _____

_____ US Citizen: Yes ___ No ___

Tel No.: Home: _____ Wk: _____ Cell: _____

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

II. BUSINESS INTERESTS:

Name: _____ **Value:** _____

Address: _____

Tel No.: Office _____ Fax: _____

E-Mail Address: _____

Succession Planning: [] Public, or Private Sale [] Buy & Sell Agreement [] Family

Continuation

[] Insurance [] Gifts & Transfers [] Key Man [] Consulting Agreement [] Independent

Board of Directors [] Other _____

III. HEALTH RELATED PROBLEMS

Health Problems: Client

Health Problems: Spouse/Significant Other

IV. CAPACITY

Are there any known problems with the individual’s memory or understanding?

Client: Yes _____ No _____

Spouse/Significant

Other: Yes _____ No _____

If you answered yes, please describe the nature of the problem:

Please indicate Yes or No to the following questions:

	<u>Client</u>	<u>Spouse/Significant Other</u>
Is the individual able to sign his or her name?	_____	_____
Able to speak?	_____	_____
Able to recognize family members and acquaintances?	_____	_____
Cognizant of his or her property and personal possessions?	_____	_____
Able to travel outside his or her current place of residence?	_____	_____

V. PHYSICIAN’S INFORMATION

(Please list the name and address of your primary physician)

	<u>Client</u>	<u>Spouse/Significant Other</u>
Physician’s Name:	_____	_____
Specialty:	_____	_____
Address:	_____	_____
	_____	_____
Business Telephone:	_____	_____

VI. RESIDENCE – OWNED

A. Owner(s): _____

B. How is the title held? _____

PLEASE PROVIDE US WITH A COPY OF THE DEED AND MOST RECENT TAX BILL.

C. Fair Market Value? \$ _____
Outstanding Mortgage _____
D. (list amount): \$ _____

If so, is it a Reverse Annuity Mortgage (RAM)? Yes _____ No _____

Basic terms: _____

E. Single family residence? Yes _____ No _____

F. If the property was purchased, please provide the following:

1. Number of units: _____

2. Currently being rented? Yes _____ No _____

3. Are tenants under lease? Yes _____ No _____

G. If the property was purchased, please provide the following:

1. Date of purchase: _____

2. Purchase price: \$ _____

H. If the property was inherited, please provide the following:

1. Month/year of inheritance _____

2. Value on date of inheritance:
(if available) \$ _____

I. If improvements have been made to the property, please detail the value and nature of the improvements:

J. Has (have) the owner(s) used the principal residence capital gains tax exclusion? Yes _____ No _____

K. If at least one occupant of the residence is a child of the individual needing long-term care, has that child lived in the residence for at least two (2) years? Yes _____ No _____

1. Has the child provided personal care to the parent(s) that might have delayed the need for long-term care for the parent(s)? Yes _____ No _____

2. If yes, please describe the nature and duration of the care provided:

L. Do the individual(s) needing care have any living children who are disabled? Yes _____ No _____

If yes, please describe the nature of the disability:

M. If the owner has a brother or sister, has the brother or sister lived in the house for at least one (1) year? Yes _____ No _____

If yes, does the sibling still reside in the home? Yes _____ No _____

VII. RESIDENCE – RENTED

Monthly Cost: \$ _____

Type of rental: Single Family _____ Apartment _____
 Residential Care _____ Life Care _____
 Senior Housing _____

Is there a rental or lease agreement? Yes _____ No _____

Is the rent being subsidized? Yes _____ No _____

If so, by whom and for how much? _____ \$ _____

VIII. LONG-TERM CARE (LTC)

	<u>Client</u>	<u>Spouse/Significant Other</u>
Is the individual(s) currently receiving long-term care? <i>(please indicate yes or no)</i>	_____	

If so, what was the date of entry into the nursing home or facility, or the date the home care was started? _____

Name of the LTC facility/provider: _____

Address: _____

Business Telephone: _____

Administrator or other contact: _____

IX. HOSPITAL

Client
Spouse/Significant Other

Is either individual currently in a hospital?
Please indicate yes or no.

Name/Location of the Hospital: _____

Date admitted: _____

Please list the current duration of the hospital stay, and a brief description of the medical problem:

Client
Spouse/Significant Other

Is placement in a LTC facility expected?
Please indicate yes or no.

If placement is expected, is it likely that he or she will return home?

X. INCOME

In completing the following section, use the “name on the check” rule, i.e., the individual(s) whose name appears on the payment vehicle is the “owner” of the income.

<u>Fixed Monthly</u>	<u>Client</u>	<u>Spouse/Significant Other</u>	<u>Joint</u>
Social Security	\$ _____	\$ _____	\$ _____
R.R. Retirement	\$ _____	\$ _____	\$ _____
Pension	\$ _____	\$ _____	\$ _____
Other (describe)			
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
Non-Fixed Monthly			
Interest	\$ _____	\$ _____	\$ _____
Dividends	\$ _____	\$ _____	\$ _____
Other (describe)			
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
TOTAL INCOME	\$ _____	\$ _____	\$ _____

XI. ASSETS/RESOURCES

Cash, CDs and Bank Balances:

<u>Name of Bank/Branch</u>	<u>Account No.</u>	<u>Type of Account</u>	<u>Balance/ Current Value</u>	<u>How Title Held</u>

Securities (Bonds, Marketable Securities, etc.): (Or attach stock brokerage account statement)

<u>Company/Insurer</u>	<u>Type (Common/ Preferred)</u>	<u>No. of Shares/ Face Value</u>	<u>Cost</u>	<u>Current Value</u>	<u>How Title Held</u>

Life Insurance:

<u>Company/Policy #</u>	<u>Name of Insured</u>	<u>Face Value</u>	<u>Current Cash Surrender Value</u>	<u>Owner of Policy</u>	<u>Named Beneficiary(s)</u>

IRA, Keogh, and/or Other Retirement Plans (provide copies of plan documents and beneficiary designations):

<u>Institution Where Held/Acct. No.</u>	<u>Owner</u>	<u>Beneficiary</u>	<u>Date Established</u>	<u>Current Value</u>
#				\$
#				\$
#				\$
#				\$

Real Estate: Please provide us with a copy of the deed and most recent tax bill.

<u>Description</u> (Location)	<u>Title Held</u>	<u>Cost/Basis</u>	<u>Outstanding</u> <u>Mortgages</u>	<u>Market Value</u>
1.				
2.				
3.				

Personal Property: (Indicate how ownership is held)

	<u>Value</u>	<u>How Held</u>
Home Furnishings:	\$	
Automobiles, Boats, etc.	\$	
Jewels &/or furs:	\$	
Other (collections, etc.)	\$	

Rights or Interests in Trusts, Estates, or Prospective Inheritance:

Briefly describe or give the name of the Trust in which the individual(s) needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

Miscellaneous:

If either (or both) individual(s) needing long-term care has any property interests not described above, please explain the nature of the interest and the estimated value thereof:

XII. EXEMPT RESOURCES

Under the Medicaid rules, certain items are “exempt” from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the individual needing care has the listed items: (please indicate yes or no)

	<u>Client</u>	<u>Spouse/Significant Other</u>
Burial plot: (Please provide a copy of deed)		

Irrevocable burial fund contract:
(Please provide a copy)

XIII. RESPONSIBLE PERSONS

Who now has “assistance” responsibilities (i.e., are any family member or other individuals providing custodial or other types of care to the individual needing assistance)? Please list name, phone number, and relationship to the person receiving the care:

For Client:

For Spouse/Significant Other:

XIV. UNAVAILABLE CHILD(REN)

If the individual needing care has children, and any child(ren) are not to be relied upon for any reason to help with management or other needs of parent(s), please list name of such child(ren) and provide a short explanation why you believe such is the case:

XV. COST OF LIVING (ESTIMATED PER MONTH)

<u>Housing</u>	<u>Client</u>	<u>Spouse/Significant Other</u>	<u>Joint</u>
If home is owned, estimate total cost of mortgage, taxes, utilities, phone, etc.* (Monthly)	\$ _____	\$ _____	\$ _____
If rented, estimate monthly rental/lease expense (including any maintenance fees)	\$ _____	\$ _____	\$ _____
<u>Insurance Premiums</u> (Monthly)			
Health	\$ _____	\$ _____	\$ _____
Long-term care	\$ _____	\$ _____	\$ _____
Other (specify):	\$ _____	\$ _____	\$ _____

<u>Medical Expenses</u>	_____	_____	_____
Non-covered medications (monthly est.)	\$ _____	\$ _____	\$ _____
Other (specify):	\$ _____	\$ _____	\$ _____
	_____	_____	_____
<u>Basic Living Expenses</u>			
Food	\$ _____	\$ _____	\$ _____
Entertainment & Travel	\$ _____	\$ _____	\$ _____
Support for child(ren)	\$ _____	\$ _____	\$ _____
Other (specify):	\$ _____	\$ _____	\$ _____
	_____	_____	_____
TOTALS	\$ _____	\$ _____	\$ _____

* Is the senior citizen real property tax exemption being used? Yes _____ No _____

Is the veterans real property tax exemption being used? Yes _____ No _____

XVI. HEALTH AND LTC INSURANCE
Use back of form if necessary (Please provide us with a copy of each document)

If either and/or both individual(s) have Medicare Parts A, B and/or D, private health or long-term care insurance, or are paying for a Medicare supplement policy, please provide the following information:

<u>Name of Insurer and Policy #</u>	<u>Type of Policy</u>	<u>Monthly Premium</u>	<u>If LTC Insurance Daily Benefit</u>
_____		\$ _____	\$ _____
_____		\$ _____	\$ _____
_____		\$ _____	\$ _____
_____		\$ _____	\$ _____

XVII. TRANSFERS WITHIN 60 MONTHS

Has the individual(s) transferred property to someone other than his or her spouse within the past sixty (60) months? If so, please provide the following information:

Client:

<u>Recipient</u>	<u>Amount</u>	<u>Date</u>
	\$ _____	_____

\$

Gift tax returns filed on any gifts? (Please provide copies, if available) Yes or No

Spouse/Significant Other:

<u>Recipient</u>	<u>Amount</u>	<u>Date</u>
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\$

\$

\$

Gift tax returns filed on any gifts? (Please provide copies, if available) Yes or No

XVIII. TRANSFERS TO OR FROM TRUSTS

Has the individual(s) transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past sixty (60) months?

Client: Yes _____ No _____

Spouse/Significant Other: Yes _____ No _____

If so, please provide the following information:

<u>Name of Trust</u>	<u>Amount</u>	<u>Date</u>
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\$

\$

Please complete the portions of following paragraphs that provide for the names of personal representatives and alternates below.

XIX. LAST WILL AND TESTAMENT:

A. PERSONAL PROPERTY

(1) [] Specific Bequests: _____

(2) [] Spouse, then children, or their issue in equal shares.

(3) [] Refer to list provided to Personal Representative of Estate.

(4) [] Other: _____

B. RESIDUARY

[] To spouse, then children

[] To children

[] Other: _____

C. EXECUTOR:

Name:

Address:

(1) _____, _____

(2) _____, _____

(3) _____, _____

D. TRUSTEE:

Name:

Address:

(1) _____, _____

(2) _____, _____

(3) _____, _____

XX. HEALTH CARE PROXY:

Name:

Address:

Phone:

(1) _____, _____, _____

(2) _____, _____, _____

(3) _____, _____, _____

XXI. DISPOSITION OF REMAINS APPOINTMENT:

Name:

Address:

Phone:

(1) _____, _____, _____

(2) _____, _____, _____

(3) _____, _____, _____

Funeral Instructions (If any):

Cremation Memorial Service Calling Hours Open casket Closed casket Service at Funeral Home Service/Mass in Church With casket Interment service at Cemetery Other: _____

Funeral Home: _____
Cemetery Plot _____

XXII. DURABLE POWER OF ATTORNEY

Principal Name: (H) _____ (W) _____

Agent(s) Names and Addresses:

- (1) _____, _____
- (2) _____, _____
- (3) _____, _____

Agents to act TOGETHER or SEPARATELY?

Successor Agent(s)

Successor Agent Name: _____

Address: _____

Alternate Successor Agent Name: _____

Address: _____

Alternate Successor Agent Name: _____

Address: _____

Successor or Alternate Agents to act TOGETHER or SEPARATELY?

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