



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.

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DATED: \_\_\_\_\_

**SECTION 1 - PERSONAL INFORMATION**

	<u>First</u>	<u>Middle</u>	<u>Last</u>
Name of Person completing form:	_____		
Home Address:	_____		

Relationship to person(s) described below: \_\_\_\_\_  
Client's Full Name: \_\_\_\_\_

Spouse's Full Name: \_\_\_\_\_  
(if applicable)  
Home Address: \_\_\_\_\_  
\_\_\_\_\_

	<u>Client</u>	<u>Spouse</u>
Telephone Number:	(h) _____	(h) _____
	(c) _____	(c) _____

Date of Birth: \_\_\_\_\_  
Date and Place of Marriage: \_\_\_\_\_  
Former / Maiden Name(s): \_\_\_\_\_  
US Citizen                      Yes \_\_\_\_\_      No \_\_\_\_\_      Yes \_\_\_\_\_      No \_\_\_\_\_

Social Security #: \_\_\_\_\_

Military Service: \_\_\_\_\_  
If deceased, date of death: \_\_\_\_\_

**SECTION 2. MARITAL INFORMATION**

Date of Marriage: \_\_\_\_\_  
Place of Marriage (City, State, Country): \_\_\_\_\_

If either spouse has been married before, please provide the date and place of divorce, if applicable:

**Client:**

<u>Name of Former Spouse</u>	<u>Date of Marriage</u>	<u>Place of Marriage</u>	<u>Year Terminated</u>

**Spouse/Significant Other:**

<u>Name of Former Spouse</u>	<u>Date of Marriage</u>	<u>Place of Marriage</u>	<u>Year Terminated</u>

If a former spouse is still alive, please list the name and describe the relationship with the former spouse:

\_\_\_\_\_

\_\_\_\_\_

**SECTION 3. KEY FAMILY INFORMATION**

Children (living and deceased). Indicate if adopted, and give the date adopted and the court granting adoption order. Indicate if deceased by putting "D" and give date of death next to name. Please indicate whether any deceased child left any surviving children.

A. **Children of present marriage:**

<u>Name</u>	<u>Address</u>	<u>Phone Number(s)</u>	<u>Date of Birth</u>	<u>SS#</u>
1.				
2.				
3.				
4.				

B. Children of prior marriage: Client

Name                      Address                      Phone Number(s)                      Date of Birth                      SS#

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- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

C. Children of prior marriage: Spouse/Significant Other

Name                      Address                      Phone Number(s)                      Date of Birth                      SS#

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- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

D. Do any children have “special needs?” (Explain: Use back of sheet if necessary). For example, think about their health and general financial status, including needs and abilities.

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**SECTION 4. DISPOSITIVE PLANNING**

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations. **Please note that we expect that this will be completed during our first conference with you regarding estate planning. You may want to use this section as items to consider before our conference.**

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.)

- 1. Client #1:  
To your Spouse/Significant other if he/she survives you?     Yes     No  
If Spouse/Significant Other does not survive you:

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If neither Spouse/Significant Other, nor children survive you:

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2. Client #2:

Does Spouse/Significant Other survive you? Yes  No

If Spouse/Significant Other does not survive you:

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If neither Spouse/Significant Other nor children survive you:

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3. Any specific disposition of your residence?

Client #1:

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Client #2:

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4. Any specific gifts of special articles, such as art or jewelry?

Client #1:

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Client #2:

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5. Household and personal effects:

Client #1:

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Client #2:

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***Include here any information that you think is important to your estate planning.***

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**SECTION 5. FIDUCIARIES**

Please consider the following information regarding the appointment of fiduciaries. Please give the name, address, telephone number and relationship, if any, of your chosen fiduciaries listed below. For each, specify order of preference of alternates by numbering. *We will discuss this section at our conference and will assist you with the completion.*

	<u>Name, Address and Telephone Number</u>	<u>Relationship</u>
A1. Executor	_____	_____
	_____	
2. Co-Executor	_____	_____
	_____	
3. Successor Executor	_____	_____
	_____	
	_____	
4. May surviving Co-Executor act alone?	Yes _____	No _____

	<u>Name, Address and Telephone Number</u>	<u>Relationship</u>
B1. Trustee	_____	_____
	_____	
2. Co-Trustee	_____	_____
	_____	
3. Successor Trustee	_____	_____
	_____	
	_____	
4. May surviving Co-Trustee act alone?	Yes _____	No _____

	<u>Name, Address and Telephone Number</u>	<u>Relationship</u>
C1. Trustee	_____	_____
	_____	

2. Co-Trustee \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Successor Trustee \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. May surviving Co-Trustee act alone? Yes \_\_\_\_\_ No \_\_\_\_\_

	<u>Name, Address and Telephone Number</u>	<u>Relationship</u>
D1. Guardian of Minor	_____ _____ _____	_____ _____ _____
2. Co-Guardian	_____ _____ _____	_____ _____ _____
3. Successor Guardian	_____ _____ _____	_____ _____ _____

4. May surviving Co-Guardian act alone? Yes \_\_\_\_\_ No \_\_\_\_\_

E1. Agent designated under Power of Attorney: Name and Address  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Co-Agent under Power of Attorney: Name and Address  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Should Agent and Co-Agent act separately or jointly?  
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 \_\_\_\_\_

4. Designate Successor-Agent under Power of Attorney: Name and Address

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5. Designate Agent under Health Care Proxy: Name, Address, and Telephone #

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6. Designate Successor-Agent under Health Care Proxy: Name, Address and Telephone #

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**SECTION 6. HEALTH RELATED PROBLEMS**

Health Problems: Client

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Health Problems: Spouse/Significant Other

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**SECTION 7. 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:

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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?		

**SECTION 8. 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:	_____	_____

**SECTION 9. 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 \_\_\_\_\_

**SECTION 10. 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? \_\_\_\_\_ \$ \_\_\_\_\_

**SECTION 11. LONG-TERM CARE (LTC)**

Is the individual(s) currently receiving long-term care? *(please indicate yes or no)* \_\_\_\_\_  
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: \_\_\_\_\_

**SECTION 12. HOSPITAL**

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:  
\_\_\_\_\_  
\_\_\_\_\_

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? \_\_\_\_\_

**SECTION 13. 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)			
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
<b>Non-Fixed Monthly</b>			
Interest	\$ _____	\$ _____	\$ _____
Dividends	\$ _____	\$ _____	\$ _____
Other (describe)			
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
<b>TOTAL INCOME</b>	<b>\$ _____</b>	<b>\$ _____</b>	<b>\$ _____</b>

**SECTION 14. 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>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**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 (Location)</u>	<u>Title Held</u>	<u>Cost/Basis</u>	<u>Outstanding 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.)	\$	

**Business Interests:**

If the individual(s) needing long-term care has any current business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.) of the business. Please bring a copy of any agreements, financial statements, etc.

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**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.

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**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:

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**SECTION 15. 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)		

**SECTION 16. 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:

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For Spouse/Significant Other:

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**SECTION 17. 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:

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**SECTION 18. 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 (Monthly)</u>			
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 \_\_\_\_\_

**SECTION 19. 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>
_____		\$ _____	\$ _____
_____		\$ _____	\$ _____
_____		\$ _____	\$ _____
_____		\$ _____	\$ _____

**SECTION 20. PLANNING AND OTHER DOCUMENTS**

*Use back of form if necessary (Please provide us with a copy of each document)*

Please indicate yes or no, and if you are supplying us with original or a copy.

	<u>Client</u>	<u>Spouse/Significant Other</u>
Will	_____	_____
Durable Power of Attorney	_____	_____
Health Care Proxy	_____	_____
Living Will	_____	_____
Trusts (Revocable)	_____	_____
Trusts (other)	_____	_____

**SECTION 21. 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>
	\$	
	\$	
	\$	

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

**SECTION 22. 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>
	\$	
	\$	

**SECTION 23. GOALS OF CLIENT**