PIERRO, CONNOR & STRAUSS, LLC
*Trusted Counsel*

# 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: _____

Employer:_____ Annual Income: _____

**Spouse/Partner Name: _____**

Date of Marriage or Domestic Partnership: _____ State: _____

Address: _____

_____ US Citizen: Yes_____ No ____

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

Social Security No.: _____ Date of Birth: _____

E-Mail Address: _____

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: ☐Yes ☐ No

(Ex. Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, Wisconsin and Puerto Rico)

**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:

| | **Client** | **Spouse/Significant Other** |
|---|---|---|
| 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)***

| | Client | Spouse/Significant Other |
|---|---|---|
| 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? $ _____

D. Outstanding Mortgage (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 <u>purchased</u>, 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 <u>purchased</u>, please provide the following:

1. Date of purchase: _____

2. Purchase price: $ _____

H. If the property was <u>inherited</u>, 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 <u>child</u> 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)

| | Client | Spouse/Significant Other |
|---|---|---|
| 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: _____

## 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.***

| Fixed Monthly | Client | Spouse/Significant Other | Joint |
|---|---|---|---|
| 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**:

| Name of Bank/Branch | Account No. | Type of Account | Balance/ Current Value | How Title Held |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

| Company/Insurer | Type (Common/ Preferred) | No. of Shares/ Face Value | Cost | Current Value | How Title Held |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Life Insurance:**

| Company/Policy # | Name of Insured | Face Value | Current Cash Surrender Value | Owner of Policy | Named Beneficiary(s) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

| Institution Where Held/Acct. No. | Owner | Beneficiary | Date Established | Current Value |
|---|---|---|---|---|
| # | | | | $ |
| # | | | | $ |
| # | | | | $ |
| # | | | | $ |

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

| Description (Location) | Title Held | Cost/Basis | Outstanding Mortgages | Market Value |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**Personal Property:** ***(Indicate how ownership is held)***

| | Value | How Held |
|---|---|---|
| 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)

| | Client | Spouse/Significant Other |
|---|---|---|
| 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)

| Housing | Client | Spouse/Partner | Joint |
|---|---|---|---|
| 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) | $ | $ | $ |

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| Insurance Premiums (Monthly) | | | |
| Health | $ | $ | $ |
| Long-term care | $ | $ | $ |
| Other (specify): | $ | $ | $ |
| Medical Expenses | | | |
| Non-covered medications (monthly est.) | $ | $ | $ |
| Other (specify): | $ | $ | $ |
| | $ | $ | $ |
| Basic Living Expenses | | | |
| 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:

| Name of Insurer and Policy # | Type of Policy | Monthly Premium | If LTC Insurance Daily Benefit |
|---|---|---|---|
| # | | $ | $ |
| # | | $ | $ |
| # | | $ | $ |

## 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:

| Recipient | Amount | Date |
|---|---|---|
| | $ | |
| | $ | |

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

Spouse/Significant Other:

| Recipient | Amount | Date |
|---|---|---|
| | $ | |
| | $ | |
| | $ | |

Gift tax returns filed on any gifts? (Please provide copies, if available) ☐ Yes ☐ 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:

| Name of Trust | Amount | Date |
|---|---|---|
| | $ | |
| | $ | |

**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 to Family/ Friends _____

_____

_____

(2) ☐ Spouse, then children, or their issue in equal shares

(3) ☐ Refer to list provided to Personal Representative of Estate

(4) ☐ Other: _____

### B. RESIDUARY / REMAINING ESTATE ASSETS

☐ To spouse, then children

☐ To children

☐ Other: _____

If a beneficiary predeceases you, how should their share be distributed?

☐ To His/ Her Heirs ☐ Evenly Among Other Beneficiaries ☐ Other _____

If no beneficiaries listed above survive you, please describe how you would like your estate distributed: _____

If a child or grandchild is a beneficiary and is a minor at the time of your death, at what age or ages do you want them to receive the principal? _____

### C. EXECUTOR: (To carry out Terms of the Will.)

**Name:** **Address:**

(1) _____, _____

(2) _____, _____

(3) _____, _____

### D. TRUSTEE: (Responsible to Administer the Trust.)

**Name:** **Address:**

(1) _____, _____

(2) _____, _____

(3) _____, _____

**XX. HEALTH CARE PROXY:** (To make medical decisions on your behalf if you are unable.)

| | Name: | Address: | Phone: |
|---|---|---|---|
| (1) | _____, | _____ | _____ |
| | | _____ | |
| (2) | _____, | _____ | _____ |
| | | _____ | |
| (3) | _____, | _____ | _____ |
| | | _____ | |

**XXI. DURABLE POWER OF ATTORNEY:** (To make financial decisions if you are unable.)
Note: A Separate Power of Attorney can be made for Business matters.

☐ Springing ☐ General Durable

| | **Name:** | **Address:** | **Phone:** |
|---|---|---|---|
| (1) | _____, | _____ | _____ |
| | | _____ | |
| (2) | _____, | _____ | _____ |
| | | _____ | |
| (3) | _____, | _____ | _____ |
| | | _____ | |

Agents to act: ☐ TOGETHER or ☐ SEPARATELY?

Agent(s) to be given Gifting Authority: ☐ Yes ☐ No

**Successor Agent(s):** (If your Primary Agent(s) above is unable or refuse to serve)

Successor Agent Name: _____

Address: _____

_____

**XXII. DISPOSITION OF REMAINS APPOINTMENT:** (Designated to handle one's remains and final arrangements once deceased.)

| | Name: | Address: | Phone: |
|---|---|---|---|
| (1) | _____, | _____ | _____ |
| | | _____ | |
| (2) | _____, | _____ | _____ |
| | | _____ | |
| (3) | _____, | _____ | _____ |
| | | _____ | |

**Funeral Instructions:** (If any – Check Applicable)

☐ 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:**_____ **Pre-Planned:** ☐ Yes ☐ No

**Cemetery Plot:** _____

**Please see the following page for a complete checklist**

# CHECKLIST OF ITEMS

**Check if you have any of the following instruments, and provide copies if available**.

| Client | Spouse/Significant Other | |
|---|---|---|
| ☐ | ☐ | Prior Will |
| ☐ | ☐ | Any existing Trust documents where listed as donor or beneficiary |
| ☐ | ☐ | Power of Attorney |
| ☐ | ☐ | Living Will and/or Health Care Proxy |
| ☐ | ☐ | Business Agreements (Partnership/Shareholder) |
| ☐ | ☐ | Pre-Nuptial Agreement |
| ☐ | ☐ | Waiver of Right of Election |
| ☐ | ☐ | Deeds to Real Property |
| ☐ | ☐ | Recent Tax Bill Associated with Deeds |
| ☐ | ☐ | Real Property Appraisals |
| ☐ | ☐ | Qualified Plan/IRA/ 401(k) Documents |
| ☐ | ☐ | Bank Account / CD Statements |
| ☐ | ☐ | Investment Statements (Stocks, Bonds, Mutual Funds) |
| ☐ | ☐ | Funeral Pre-Planning / Cemetery Plot |
| ☐ | ☐ | Life Insurance Policies |
| ☐ | ☐ | Long-Term Care Insurance Policy |
| ☐ | ☐ | Any Current Beneficiary Elections |
| ☐ | ☐ | Prior Gift Tax Returns |
| ☐ | ☐ | Last Federal Income Tax Return |

Pierro, Connor & Strauss, LLC
43 British American Boulevard, Latham, NY 12110 | Tel: 518-459-2100
60 East 42nd Street, Suite 4600, New York, NY 10165 | Tel: 212-661-2480
Toll Free: 866-951-PLAN | Email: info@pierrolaw.com
**www.pierrolaw.com**