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:wdwd_____ 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

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