

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.

DATE: \_\_\_\_\_

**SECTION 1. NAME AND CONTACT INFORMATION**

Person Completing Form: \_\_\_\_\_  
(first) (middle) (last)

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Client's Full Name: \_\_\_\_\_  
(first) (middle) (last)

Spouse's Full Name: \_\_\_\_\_  
(first) (middle) (last)

Home Address: \_\_\_\_\_  
\_\_\_\_\_

**Client**

**Spouse**

Telephone Numbers: \_\_\_\_\_  
(home) (home)

\_\_\_\_\_ (cell) (cell)

Date of Birth: \_\_\_\_\_

Former/Maiden Names: \_\_\_\_\_

US Citizen?: [ ] Yes [ ] No [ ] Yes [ ] No

Social Security Number: \_\_\_\_\_

Military Service: \_\_\_\_\_

Date of Death: \_\_\_\_\_

**SECTION 2. MARITAL INFORMATION**

A. Date of Marriage: \_\_\_\_\_

B. Place of Marriage: \_\_\_\_\_  
(city) (state or province) (country)

**C. Client's Former Spouses:**

1. \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?) (if still living, describe relationship)

2. \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?) (if still living, describe relationship)

3. \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?) (if still living, describe relationship)

**D. Spouse's Former Spouses:**

1. \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?) (if still living, describe relationship)

2. \_\_\_\_\_  
(name of former spouse) (date of marriage) (place of marriage)  
\_\_\_\_\_  
(year terminated)  Death  Divorce  
(how terminated)  
 Yes  No  
(still living?) (if still living, describe relationship)

3. \_\_\_\_\_ (name of former spouse) \_\_\_\_\_ (date of marriage) \_\_\_\_\_ (place of marriage)  
 \_\_\_\_\_ (year terminated)  Death  Divorce \_\_\_\_\_ (how terminated)  
 Yes  No \_\_\_\_\_ (still living?) \_\_\_\_\_ (if still living, describe relationship)

**SECTION 3. CHILDREN**

List all children. Copy and attach additional pages, if needed. Total number of children: \_\_\_\_\_

1. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)  
 Parent:  Client  Spouse  Both  
 \_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)  
 Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)  
 Deceased \_\_\_\_\_ (date of death)  Yes  No \_\_\_\_\_ (child has surviving children?)

\_\_\_\_\_  
 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
 (Use additional pages, if needed)

2. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)  
 Parent:  Client  Spouse  Both  
 \_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)  
 Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)  
 Deceased \_\_\_\_\_ (date of death)  Yes  No \_\_\_\_\_ (child has surviving children?)

\_\_\_\_\_  
 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
 (Use additional pages, if needed)

3. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)

Parent:  Client  Spouse  Both

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)

Deceased \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
(Use additional pages, if needed)

4. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)

Parent:  Client  Spouse  Both

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)

Deceased \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
(Use additional pages, if needed)

5. \_\_\_\_\_ (name of child) \_\_\_\_\_ (date of birth) \_\_\_\_\_ (social security number)

Parent:  Client  Spouse  Both

\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

Adopted \_\_\_\_\_ (date of adoption) \_\_\_\_\_ (court granting adoption)

Deceased \_\_\_\_\_ (date of death)  Yes  No (child has surviving children?)

\_\_\_\_\_  
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
(Use additional pages, if needed)

6. \_\_\_\_\_  
 (name of child) (date of birth) (social security number)

Parent:  Client  Spouse  Both

\_\_\_\_\_  
 (current address) (phone number)

Adopted \_\_\_\_\_  
 (date of adoption) (court granting adoption)

Deceased \_\_\_\_\_  Yes  No  
 (date of death) (child has surviving children?)

\_\_\_\_\_  
 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

\_\_\_\_\_  
 (Use additional pages, if needed)

**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.).

A. First-choice beneficiaries:  Spouse  Children  Spouse and Children  Other

\_\_\_\_\_

\_\_\_\_\_

B. Second-choice beneficiaries:  Spouse  Children  Spouse and Children  Other

\_\_\_\_\_

\_\_\_\_\_

C. Third-choice beneficiaries:  Spouse  Children  Spouse and Children  Other

\_\_\_\_\_

\_\_\_\_\_

D. Any specific disposition of your residence?

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

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F. Any specific disposition of household and personal effects?

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G. Other information you think is important to your estate planning:

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**SECTION 5. FIDUCIARIES**

Please consider the who you want to handle your affairs when you cannot. *We will discuss this section at our conference and will assist you with the completion.*

**A. EXECUTORS (Co-Executors Act:  Separately or  Jointly)**

1. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

2. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
 Co-Executor with Previous Name (May surviving Co-Executor act alone?  Yes  No)  
or  Successor Executor  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

3. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)  
or [ ] Successor Executor  
  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

4. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)  
or [ ] Successor Executor  
  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

**B. TRUSTEES (Co-Trustees Act: [ ] Separately or [ ] Jointly)**

1. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

2. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)  
or [ ] Successor Trustee  
  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

3. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)  
or [ ] Successor Trustee  
  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

4. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)  
or [ ] Successor Trustee  
  
\_\_\_\_\_ (current address) \_\_\_\_\_ (phone number)

**C. GUARDIANS OF MINOR CHILDREN (Co-Guardians Act:  Separately or  Jointly)**

1. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

2. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
 Co-Guardian with Previous Name (May surviving Co-Guardian act alone?  Yes  No)  
or  Successor Guardian  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

3. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
 Co-Guardian with Previous Name (May surviving Co-Guardian act alone?  Yes  No)  
or  Successor Guardian  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

4. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
 Co-Guardian with Previous Name (May surviving Co-Guardian act alone?  Yes  No)  
or  Successor Guardian  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

**D. AGENTS UNDER POWER OF ATTORNEY (Co-Agents Act:  Separately or  Jointly)**

1. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

2. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
 Co-Agent with Previous Name (May surviving Co-Agent act alone?  Yes  No)  
or  Successor Agent  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)



3. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)  
or [ ] Successor Agent  
  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

4. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)  
or [ ] Successor Agent  
  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

**E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY**

1. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

2. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

3. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

4. \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)  
  
\_\_\_\_\_  
(current address) \_\_\_\_\_ (phone number)

**SECTION 6. HEALTH-RELATED PROBLEMS**

Please describe any specific health-related problems.

**A. Client**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Spouse**

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**SECTION 7. CAPACITY**

**A. MEMORY AND UNDERSTANDING**

Are there any known problems with memory or understanding?

Client:  Yes  No

Spouse:  Yes  No

If yes, please explain:

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**B. OTHER ISSUES**

	<b><u>Client</u></b>	<b><u>Spouse</u></b>
Able to sign name?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to speak?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to recognize friends and family?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cognizant of property and possessions?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to leave current residence?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 8. PHYSICIAN INFORMATION**

Please list the name, specialty, address, and phone number of your primary physician.

	<b><u>Client</u></b>	<b><u>Spouse</u></b>
Physician's Name:	_____	_____
Specialty:	_____	_____

Address: \_\_\_\_\_

\_\_\_\_\_

Business Phone: \_\_\_\_\_

**SECTION 9. RESIDENCE -- OWNED**

A. Owners: \_\_\_\_\_

B. How is title held? \_\_\_\_\_

**PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL**

C. Fair Market Value: \$ \_\_\_\_\_

D. Mortgage Balance: \$ \_\_\_\_\_

Is it a Reverse Annuity Mortgage (RAM)?  Yes  No

Basic Mortgage Terms: \_\_\_\_\_

E. Single Family Residence?  Yes  No

F. If the property is rental property, 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 Inherited: \_\_\_\_\_

2. Value when Inherited: \$ \_\_\_\_\_

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

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J. Have the owners used the capital gains tax exclusion?  Yes  No

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

1. If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent?  Yes  No

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

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L. Does the person needing care have any living children who are disabled?  Yes  No

If yes, please describe the nature of the disability:

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M. Does the owner have a sibling who has lived in the house for at least 1 year?  Yes  No

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

**SECTION 10. RESIDENCE -- RENTED**

A. Monthly Rent: \$ \_\_\_\_\_

B. Type of Rental:  Single Family  Apartment  Residential Care  
 Life Care  Senior Housing

C. Rental/Lease Agreement?  Yes  No

D. Is Rent Subsidized?  Yes  No

If so, by whom and amount? \_\_\_\_\_

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

**A. Client**

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: \_\_\_\_\_

Name of Facility/Provider: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Business Phone: \_\_\_\_\_

Administrator or Contact: \_\_\_\_\_

**B. Spouse**

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: \_\_\_\_\_

Name of Facility/Provider: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Business Phone: \_\_\_\_\_

Administrator or Contact: \_\_\_\_\_

**SECTION 12. HOSPITAL**

**A. Client**

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: \_\_\_\_\_

Name/location of hospital: \_\_\_\_\_

Description of medical issue: \_\_\_\_\_

\_\_\_\_\_

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

**B. Spouse**

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: \_\_\_\_\_

Name/location of hospital: \_\_\_\_\_

Description of medical issue: \_\_\_\_\_

\_\_\_\_\_

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

**SECTION 13. INCOME**

In completing the following section, use the “name on the check” rule; that is, the person whose name appears on the payment vehicle is the “owner” of the income.

**A. FIXED MONTHLY INCOME**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Social Security:	\$ _____	\$ _____	\$ _____
2. R.R. Retirement:	\$ _____	\$ _____	\$ _____
3. Pension:	\$ _____	\$ _____	\$ _____
4. _____:	\$ _____	\$ _____	\$ _____
5. _____:	\$ _____	\$ _____	\$ _____
6. _____:	\$ _____	\$ _____	\$ _____

**B. NON-FIXED MONTHLY INCOME**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Interest:	\$ _____	\$ _____	\$ _____
2. Dividends:	\$ _____	\$ _____	\$ _____
3. _____:	\$ _____	\$ _____	\$ _____

4. \_\_\_\_\_ : \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

5. \_\_\_\_\_ : \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

C. TOTALS (A thru B): \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

**SECTION 14 ASSETS AND RESOURCES**

**A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)**  
**(Please provide copies of statements)**

<u>Name of Bank/Branch</u>	<u>Account No.</u>	<u>Type of Account</u>	<u>Balance/Value</u>	<u>How Title Held</u>
Big Bank/Main St. <small>(sample)</small>	xxx-xxxx	Savings	\$ xx,xxx.xx	Jointly w/ son
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____

**B. SECURITIES (Bonds, Marketable Securities, etc.)**  
**(Please provide copies of statements)**

<u>Name of Company</u>	<u>Type of Sec.</u>	<u># Shares/Face Val.</u>	<u>Cost</u>	<u>Current Val.</u>	<u>How Title Held</u>
Acme Corp. <small>(sample)</small>	Common <small>(or Preferred)</small>	xx Shares	\$ x,xxx.xx	\$ x,xxx.xx	Sole owner
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____

**C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)**

(Please provide copies of statements and beneficiary designations)

<u>Name of Institution</u>	<u>Account No.</u>	<u>Owner</u>	<u>Beneficiary</u>	<u>Date Est.</u>	<u>Current Value</u>
Big Broker	xxx-xxxx	Client	Spouse	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

**D. REAL ESTATE**

(Please provide copies of deeds and most recent tax bills)

<u>Description (Location)</u>	<u>Cost (Basis)</u>	<u>Market Value</u>	<u>Mortgage Bal.</u>	<u>How Title Held</u>
123 Know Way	\$ xxx,xxx.xx	\$ xxx,xxx.xx	\$ xx,xxx.xx	Joint tenant
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____

**E. PERSONAL PROPERTY**

	<u>Market Value</u>	<u>How Title Held</u>
Home Furnishings:	\$ _____	_____
Cars, RVs, Boats, etc.:	\$ _____	_____
Jewels, Furs, etc.:	\$ _____	_____
_____:	\$ _____	_____
(other: collectibles, etc.)	\$ _____	_____
_____:	\$ _____	_____
_____:	\$ _____	_____



**F. BUSINESS INTERESTS**

If the person needing long-term care has any 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.). Please bring a copy of any agreements, financial statements, etc.

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**G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES**

Briefly describe or give the name of the Trust in which the person 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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**H. MISCELLANEOUS**

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each (but not life insurance—see Section 20).

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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 person needing care has the listed items.

	<b><u>Client</u></b>	<b><u>Spouse</u></b>
Burial plot:	[ ] Yes [ ] No	[ ] Yes [ ] No
Irrevocable burial fund contract:	[ ] Yes [ ] No	[ ] Yes [ ] No

**SECTION 16. PEOPLE PROVIDING ASSISTANCE**

Who now has “assistance” responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

**A. Responsible for Client:**

1. \_\_\_\_\_  
(name of responsible person) (phone number) (relationship to person needing care)
2. \_\_\_\_\_  
(name of responsible person) (phone number) (relationship to person needing care)
3. \_\_\_\_\_  
(name of responsible person) (phone number) (relationship to person needing care)

**B. Responsible for Spouse:**

1. \_\_\_\_\_  
(name of responsible person) (phone number) (relationship to person needing care)
2. \_\_\_\_\_  
(name of responsible person) (phone number) (relationship to person needing care)
3. \_\_\_\_\_  
(name of responsible person) (phone number) (relationship to person needing care)

**SECTION 17. UNAVAILABLE CHILDREN**

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

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**SECTION 18. MONTHLY COST OF LIVING**

**A. HOUSING (ESTIMATED PER MONTH)**

	<b><u>Client</u></b>	<b><u>Spouse</u></b>	<b><u>Joint</u></b>
1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*: \$ _____	\$ _____	\$ _____	\$ _____
2. If home is rented, total rent, including maint. fees, if any: \$ _____	\$ _____	\$ _____	\$ _____

\* Is the senior citizen real property tax exemption being used? [ ] Yes [ ] No  
Is the veterans real property tax exemption being used? [ ] Yes [ ] No

**B. INSURANCE PREMIUMS (PER MONTH)**

	<b><u>Client</u></b>	<b><u>Spouse</u></b>	<b><u>Joint</u></b>
1. Health insurance: \$ _____	\$ _____	\$ _____	\$ _____
2. Long-term care insurance: \$ _____	\$ _____	\$ _____	\$ _____
3. _____: \$ _____ (specify)	\$ _____	\$ _____	\$ _____
4. _____: \$ _____ (specify)	\$ _____	\$ _____	\$ _____

**C. MEDICAL EXPENSES (ESTIMATED PER MONTH)**

	<b><u>Client</u></b>	<b><u>Spouse</u></b>	<b><u>Joint</u></b>
1. Non-covered medications: \$ _____	\$ _____	\$ _____	\$ _____
2. _____: \$ _____ (specify)	\$ _____	\$ _____	\$ _____
3. _____: \$ _____ (specify)	\$ _____	\$ _____	\$ _____

**D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)**

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Food:	\$ _____	\$ _____	\$ _____
2. Entertainment and travel:	\$ _____	\$ _____	\$ _____
3. Support for children:	\$ _____	\$ _____	\$ _____
4. _____: (specify)	\$ _____	\$ _____	\$ _____
5. _____: (specify)	\$ _____	\$ _____	\$ _____
<b>E. TOTALS (A thru D):</b>	<b>\$ _____</b>	<b>\$ _____</b>	<b>\$ _____</b>

**SECTION 19. HEALTH AND LTC INSURANCE**

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

<u>Name of Insurer</u>	<u>Policy No.</u>	<u>Type of Policy</u>	<u>Monthly Prem.</u>	<u>If LTC, Daily Benefit</u>
Acme Insurance (sample)	123-45-6789	Long-term care	\$ 3,000	\$ 300.00 per day
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

**SECTION 20. LIFE INSURANCE**

If the person needing care has life insurance, please provide the following information:

<u>Name of Insurer</u>	<u>Policy No.</u>	<u>Type of Policy</u>	<u>Monthly Prem.</u>	<u>Cash Surrender Value</u>
Acme Insurance (sample)	123-45-6789	Whole Life	\$ 1,000	\$ 10,000
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

**SECTION 21. PLANNING AND OTHER DOCUMENTS**

Please provide a copy of each document.

	<u>Client</u>	<u>Spouse</u>
Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No	[ ] Yes [ ] No
Pour-Over Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Health Care Power of Attorney (or Proxy):	[ ] Yes [ ] No	[ ] Yes [ ] No
Living Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No	[ ] Yes [ ] No

(specify)

**SECTION 22. TRANSFERS WITHIN 60 MONTHS**

Has the person needing care (or his or her spouse) gratuitously transferred property to someone other than transferor's spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**: Please include transfers for financial assistance to anyone, other than in exchange for work.

**A. Client**

<u>Recipient</u>	<u>Amount/Value of Gift</u>	<u>Date of Gift</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____
4. _____	\$ _____	_____

**B. Spouse**

<u>Recipient</u>	<u>Amount/Value of Gift</u>	<u>Date of Gift</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____
4. _____	\$ _____	_____

