Elder Law & Disability Planning Questionnaire

Reason for visit (check all that apply):
☐ Estate Planning (Wills, Trusts, Healthcare Documents, Deeds) ☐ Guardianship ☐ Probate ☐ Elder Law Issues (Asset Protection, Medicaid/Medicare Planning, Other Related Issues)

Client	*Spouse*
Name	Name
Address	Address
Home Phone	Home Phone
Cell Phone	Cell Phone
Email	Email
Birthdate	Birthdate
SSN	SSN

Have you or your spouse been married before ? ☐ Yes ☐ No
If yes, do you or your spouse have any children from this previous marriage? ☐ Yes ☐ No
Do you or your spouse have children who have died leaving children? ☐ Yes ☐ No
Does anyone to whom you may be leaving part of your estate require any help or protection in managing money or other property? ☐ Yes ☐ No
Do you and your spouse have a pre-nuptial or post-nuptial agreement? ☐ Yes ☐ No

MEDICAL/DISABILITY

Is anyone in your family disabled? ☐ Yes ☐ No If yes, please explain
Is anyone at risk for becoming seriously ill or disabled because of a medical condition or family history? ☐ Yes ☐ No If yes, please explain
Has anyone in your family recently entered a hospital or skilled nursing facility? ☐ Yes ☐ No If yes: Name of facility Date of admission Date of discharge Diagnosis
Please describe client's physical and mental condition
Please describe client's spouse's physical and mental condition
Do any other family members have a disability? ☐ Yes ☐ No If yes: Name and relationship Describe the disability
Is either the client or the client's spouse currently a patient of a nursing home, ALF or hospital? ☐ Yes ☐ No If yes: Nursing home patient Name of nursing home, ALF or hospital Date of admission to the hospital nursing home ALF
Please provide any other information that you believe will be beneficial to the planning process:
What medical or health problems do you currently have?
What medical problems have you had in the past?
Please list all of the medications you are currently taking and why you are taking it:

_____

_____

_____
_____
_____
_____
_____

Does your family have a history of health problems (for example, heart disease, cancer, or Alzheimer's disease)? ☐ Yes ☐ No If yes, describe
Mother's age at death _____ Cause of death _____
Father's age at death _____ Cause of death _____

Name of your persona1 physician(s):

Name	Name
Address :	Address :
Phone	Phone
Email :	Email :
Specialty :	Specialty :

HEALTH AND LTC INSURANCE

Client's Medicare Number Spouse's Medicare Number
Insurance from Employer Medicare Supplement
Long-Term Care Insurance Other

*Activities of Daily Living (*Mark the box that best applies for each activity.)

Activity	**Need No Help**	**Need Some Help**	**Unable to Do Without Help**
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Transferring from bed to chair	☐	☐	☐
Walking	☐	☐	☐
Feeding self	☐	☐	☐
Using the toilet	☐	☐	☐
Grooming	☐	☐	☐
Public transport	☐	☐	☐
Using the telephone	☐	☐	☐
Grocery shopping	☐	☐	☐
Preparing meals	☐	☐	☐
Managing money	☐	☐	☐
Doing laundry	☐	☐	☐
Doing housework	☐	☐	☐

or handyman work			
Taking medications	☐	☐	☐

List the names(s) and address (es) of all person(s) or agency providing assistance or caregiving for you:

_____
_____
_____
_____

Where do you live?
☐ Single-family home or townhome ☐ Apartment or retirement living community ☐ Assisted-living facility ☐ Nursing home ☐: Other
Since When?

CHILDREN

Children

Name	Address	Phone	Birthdate

Grandchildren

Name	Address	Phone	Birthdate

Are any of your children blind? ☐ Yes ☐ No
Are any of your children disabled? ☐ Yes ☐ No
Do any of your children live with you in your home? ☐ Yes ☐ No

LEGAL DOCUMENTS

Document	State Where Executed	Location of Original	Date Executed
Last Will and Testament			
Durable Power of Attorney			
Living Will/Health			

Care Proxy			
Living Trust			

Are you or your spouse the beneficiary of any trust? ☐ Yes ☐ No
Do you or your spouse expect an inheritance? ☐ Yes ☐ No
I am the legally appointed guardian of
I am serving as a power of attorney for
I am serving as executor or administrator of an estate. ☐ Yes ☐ No
I am involved in a lawsuit or have reason to believe I will be involved in a lawsuit. ☐ Yes ☐ No If yes, describe
Other legal concerns

FINANCIAL INFORMATION

Have you or your spouse made any uncompensated transfers or gifts to individuals or charities during the past five years? ☐ Yes ☐ No
Have you, in the past 5 years, paid money for someone else's benefit (for example, paying for a child's wedding, paying for a grandchild's education, etc.)? ☐ Yes ☐ No
Have you lost any money gambling in the past 5 years? ☐ Yes ☐ No
Have you made any loans that are still outstanding (i.e., does anybody owe you money?) ☐ Yes ☐ No
(Gifts made in excess of $1,000/year to an individual other than your spouse within the past 36 months):
Recipient Date Amount Consideration received
Recipient Date Amount Consideration received
Has the client or the client's spouse made any other person a joint owner of any asset(s)? ☐ Yes ☐ No If yes:
Recipient Date Amount Consideration received
Recipient Date Amount Consideration received
Do you or your spouse expect an inheritance? ☐ Yes ☐ No
Are you or your spouse the beneficiary of any trust? ☐ Yes ☐ No
I have lived in a community property state (Arizona, Calif., Idaho, Louisiana, Nevada, New Mexico, Texas, Washington) ☐ Yes ☐ No

Current Assets		**Current Liabilities**	
Cash on Hand or in Banks		Notes Payable (Secured)(Schedule F)	
Other Cash:		Notes Payable (Unsecured)(Schedule G)	
Real Estate (other than residence Schedule A)		Real Estate Mortgages Payable (Schedule H)	
Residence		Auto Loans (Schedule I)	
Motor Vehicles (Schedule B)		Unpaid Taxes and Interest	
US Government Securities (Schedule C)		Due to Brokers	
Non-Marketable Securities (Schedule D)		Open Accounts	
Stocks (Schedule E)		Credit Cards (List):	
Other Personal Property			
Life Insurance Cash Value			
Business Interests			
Notes Receivable			
Other Assets:		Other:	
		Total Liabilities	
		TOTAL OF ALL ASSETS	
		LESS TOTAL OF ALL LIABILITIES	
Total Assets		**NET WORTH**	
Individual Income Information (Annual)			
Salary			
Bonus			
Commissions			
Dividends			
Rental Income			
Other Income (List):			
Total Income			
Contingent Liabilities			
Guarantor, Co-maker			
Lease or Contracts			
Legal Claims			
Other:			

SCHEDULE “A” REAL ESTATE

Description of Real Estate	**Cost**	**Market Value**	**Date Acquired**
	$	$	
	$	$	
	$	$	
	$	$	
	$	$	
	$	$	
Total	**$**	**$**	

SCHEDULE "B" MOTOR VEHICLES

Description of Motor Vehicles	Cost	Value
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
Total	**$**	**$**

SCHEDULE "C" U.S. GOVERNMENT SECURITIES

Description of Stock or Bond	Date Acquired	Par Value	Market Value
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
Total		**$**	**$**

SCHEDULE "D" NON MARKETABLE SECURITIES

Description	Date Acquired	Par Value	Market Value
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
Total		**$**	**$**

SCHEDULE "E" STOCKS

Company	Shares	Date Acquired	Par Value	Market Value
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$
Total			**$**	**$**

SCHEDULE "F" NOTES PAYABLE SECURED

Description	Date	Balance	Payment (m/yr)
		$	$
		$	$
		$	$
		$	$
		$	$
Total		**$**	**$**

SCHEDULE “G” NOTES PAYABLE UNSECURED

Description	Date	Balance	Payment (m/yr)
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
	Total	**$**	**$**

SCHEDULE “H” REAL ESTATE MORTGAGES

Description	Date	Balance	Payment (m/yr)
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
	Total	**$**	**$**

SCHEDULE “I” AUTO LOANS

Description	Date	Balance	Payment (m/yr)
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
	Total	**$**	**$**

Do you or your spouse have an interest in any business? ☐ Yes ☐ No Describe

What is the private pay rate of the nursing home or assisted living facility (ALF) where the client or client’s spouse staying or will be staying? Daily Monthly

List any other expenses that are anticipated at the nursing home or ALF

What is the monthly cost of Medicare Supplement Insurance for client?

For client’s spouse

If the client’s spouse is, or going to be, in a nursing home or ALF, how much income will be needed monthly to pay ongoing expenses of the well spouse?

LEGAL AND FINANCIAL DECISIONS

If you were unable to carry out your legal and financial business, who would you want to take care of your legal, business, personal, and financial affairs?

First Choice: Name Address Phone

Second Choice: Name Address Phone

If you were in the hospital and unable to make decisions for yourself, with whom would you want your doctor to consult with about your care (that is, to be your health care advocate)?

First Choice: Name Address Phone

Second Choice: Name Address Phone

Does any potential beneficiary have special educational, medical or physical needs, or receive governmental benefits? ☐ Yes ☐ No

Does any potential beneficiary have any potential problems with drug or alcohol abuse? ☐ Yes ☐ No

Are you concerned with any potential beneficiary's ability to handle/manage money? ☐ Yes ☐ No

Are you concerned with your children's ability to get along with one another? ☐ Yes ☐ No

Are their problems/concerns relative to your relationship with your children (or spouse's children)? ☐ Yes ☐ No

Have any of your children received a divorce? ☐ Yes ☐ No

If possible, please bring copies of the following documents with you to your meeting with the attorney:

☐ Existing Durable Powers of Attorney
☐ Life insurance policies and annuities
☐ Income tax return for last year
☐ Deed(s)/Appraisals
☐ Current bank and brokerage account statements
☐ Existing Wills, Codicils, and Trust Agreements
☐ Admission Agreements to hospitals and health facilities
☐ Divorce Decrees, Prenuptial Agreements, Adoption Papers
☐ Guardianship documents
☐ Living Will, Health Care Declaration or Power of Attorney, Durable Powers of Attorney
☐ A list of full names, addresses, telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries of your estate, helpers, and advisors
☐ Retirement plans, including any forms designating beneficiaries