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 COMPLETED: ____________________________________

Name of person completing form: ____

Are you a current client? Yes______ No______

If you are completing this form for someone other than yourself and/or your spouse:

Address of person completing form: ____

____

Relationship to person(s) described below: ____

SECTION 1. PERSONAL INFORMATION

(If the individual needing long-term care is single or widowed, complete only appropriate sections)

	Husband (or Single Male)	Wife (or Single Female)
Full Name:	____________________________________	______________________________
Address:	____	
	____	
Home Telephone:	( ) ______________________________	( ) ______________________________
Business Telephone:	( ) ______________________________	( ) ______________________________
Date of Birth:	____	

Former/ Maiden Name(s): ____________________________ ___________________________________

U.S. Citizen: Yes _____ No _____ Yes _____ No _____

Social Security Number: ____________________________ ___________________________________

Military Service: ______________________________________ ___________________________________

If deceased, date of death: ______________________________ ___________________________________

SECTION 2. MARITAL INFORMATION

Date of marriage: ___________________________________

Place of marriage (City, State, Country): _____________________________

Prior Marriage(s): Husband/Single Male

Name of Former Spouse *Date of Marriage* *Place of Marriage* *Year Terminated*

____

____

____

Prior Marriage(s): Wife/Single Female

Name of Former Spouse *Date of Marriage* *Place of Marriage* *Year Terminated*

____

____

____

If a former spouse is still alive, 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: Husband/Single Male

Name(s)	Address(es)	Phone Number(s)	Date of Birth	SS#
1.				
2.				
3.				
4.				

B. Children of present marriage: Wife/Single Female

Name(s)	Address(es)	Phone Number(s)	Date of Birth	SS#
1.				
2.				
3.				
4.				

C. Children of prior marriage: Husband/Single Male

Name(s)	Address(es)	Phone Number(s)	Date of Birth	SS#
1.				
2.				
3.				
4.				

D. Children of prior marriage: Wife/Single Female

Name(s)	Address(es)	Phone Number(s)	Date of Birth	SS#
1.				
2.				
3.				
4.				

F. 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.

SECTION 4. HEALTH RELATED PROBLEMS

Husband: ____

____

____

____

Wife: ____

____

____

____

SECTION 5. CAPACITY

Are there any known problems with the individual's memory or understanding?

Husband (or Single Male): Yes _____ No ______
Wife (or Single Female): Yes _____ No ______

If you answered yes, please describe the nature of the problem: _____________________________

____

____

____

Is the individual able to sign his or her name?	Husband (or Single Male):	Yes _____	No ______
	Wife (or Single Female):	Yes _____	No ______
Able to speak?	Husband (or Single Male):	Yes _____	No ______
	Wife (or Single Female):	Yes _____	No ______
Able to recognize family members	Husband (or Single Male):	Yes _____	No ______
and acquaintances?	Wife (or Single Female):	Yes _____	No ______
Cognizant of his or her property	Husband (or Single Male):	Yes _____	No ______
and personal possessions?	Wife (or Single Female):	Yes _____	No ______
Able to travel outside his or her	Husband (or Single Male):	Yes _____	No ______
current place of residence?	Wife (or Single Female):	Yes _____	No ______

SECTION 6. PHYSICIAN'S INFORMATION

(Please list the name and address of your primary physician)

	Husband (or Single Male)	Wife (or Single Female)
Physician's name:	______________________	______________________
Specialty:	______________________	______________________
Address:	______________________	______________________
	______________________	______________________
Business Telephone:	(______) ______________	(______) ______________

SECTION 7. RESIDENCE - OWNED

(If rented, skip to Section 8)

A. Owner(s):____

B. How is 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 is a multi-family unit, 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 that 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 8. 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 9. LONG-TERM CARE (LTC)

Is the individual(s) currently receiving long-term care?
Husband (or Single Male): Yes _____ No _____
Wife (or Single Female): Yes _____ No _____

If so, what was the date of entry into the nursing home or facility, or the date the home care was started?

Husband (or Single Male):_________________Wife (or Single Female):____________________

Name of the LTC facility/provider:____
Address: ____
____

Telephone Number: ____________(_____)____
Administrator (or other contact): ____

Is the facility Medicaid-certified? Yes _____ No _____
Was the stay in the facility or the home care immediately preceded by a hospital stay? Yes _____ No _____
How long was the hospital stay? ____

SECTION 10. HOSPITAL

Is either individual currently in a hospital?
Husband (or Single Male): Yes _____ No _____ Wife (or Single Female): Yes _____ No _____
Name/location of the Hospital: ____
____
____

Please list the current duration of the hospital stay, and a brief description of the medical problem:
____
____
____

Is placement in a LTC facility expected?
Husband (or Single Male): Yes _____ No _____
Wife (or Single Female): Yes _____ No _____

If placement is expected, is it likely that he or she will return home?
Husband (or Single Male): Yes _____ No _____
Wife (or Single Female): Yes _____ No _____

SECTION 11. 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	Husband/Single Male	Wife/Single Female	Joint
Social Security	$______________	$______________	$______________
R.R. Retirement	$______________	$______________	$______________
Pension	$______________	$______________	$______________
Other (describe)			
________________________	$______________	$______________	$______________
________________________	$______________	$______________	$______________
Non-Fixed Monthly			
Interest	$______________	$______________	$______________
Dividends	$______________	$______________	$______________
Other (describe)			
________________________	$______________	$______________	$______________
________________________	$______________	$______________	$______________
TOTAL INCOME:	$______________	$______________	$______________

SECTION 12. ASSETS/RESOURCES

(You may attach a copy of a portfolio instead)

Cash, CD's and Bank Balances:

Name of Bank and Account Number	Type of Account	How is Title Held?	Current Value
______________________ # ____________________	________________	____________	$____________
______________________ # ____________________	________________	____________	$____________
______________________ # ____________________	________________	____________	$____________
______________________ # ____________________	________________	____________	$____________
______________________ # ____________________	________________	____________	$____________

Securities (Bonds, Marketable Securities, etc.)

Company or Bond Type	# of Shares/ Bond Cert.'s	How is Title Held?	Cost	Current Value
____________________	__________	__________	$ __________	$ __________
____________________	__________	__________	$ __________	$ __________
____________________	__________	__________	$ __________	$ __________
____________________	__________	__________	$ __________	$ __________
____________________	__________	__________	$ __________	$ __________

IRA, 401(k), Keogh, and/or Other Retirement Accounts:

Institution Where Held/Acct. No.	Owner	Beneficiary	Date Established	Current Value
____________ # ____________	________	________	________	$________
____________ # ____________	________	________	________	$________
____________ # ____________	________	________	________	$________
____________ # ____________	________	________	________	$________
____________ # ____________	________	________	________	$________

Life and Accident Insurance & Annuities:

Company, Policy Type and Policy Number	Owner	Beneficiary	Death Value	Current Cash Value
____________ # ____________	________	________	________	$________
____________ # ____________	________	________	________	$________
____________ # ____________	________	________	________	$________
____________ # ____________	________	________	________	$________

Real Estate:

Description/Location	How is Title Held?	Cost/Basis	Outstanding Mortgages?	Current Market Value
____________________	____________	$____________	$____________	$____________
____________________				
____________________				
____________________	____________	$____________	$____________	$____________
____________________				
____________________				
____________________	____________	$____________	$____________	$____________
____________________				
____________________				

PLEASE PROVIDE US WITH COPIES OF DEEDS AND MOST RECENT TAX BILLS FOR EACH LISTED PARCEL OF REAL PROPERTY.

Personal Property:

	How is Title Held?	Current Value
Home Furnishings:	(n/a)	$ ______________
Automobile(s) (list separately):		
____________________	______________	$ ______________
____________________	______________	$ ______________
____________________	______________	$ ______________
Other vehicle(s)(list separately):		
____________________	______________	$ ______________
____________________	______________	$ ______________
____________________	______________	$ ______________

For Items of Special Value (Antiques, jewelry, etc.), Include Description:

____________________	______________	$ ______________
____________________	______________	$ ______________
____________________	______________	$ ______________

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:

____

____

____

____

SECTION 13. 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:

Burial plot:	Husband (or Single Male)	Yes _____	No _____
(Please provide a copy of deed)	Wife (or Single Female)	Yes _____	No _____
Irrevocable burial fund contract:	Husband (or Single Male)	Yes _____	No _____
(Please provide a copy)	Wife (or Single Female)	Yes _____	No _____

SECTION 14. RESPONSIBLE PERSONS

Who now has "assistance" responsibilities (i.e., are any family members 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 Husband (or Single Male): ____
____
____

For Wife (or Single Female): ____
____
____

SECTION 15. 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 the name of such child(ren) and provide a short explanation why you believe such is the case:

____
____
____
____
____

____

SECTION 16. COST OF LIVING (ESTIMATED) PER MONTH

	Husband/Male	Wife/Female	Both
Housing			
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	$____________	$____________	$____________
Life	$____________	$____________	$____________
Other (specify):			
____________________________	$____________	$____________	$____________
____________________________	$____________	$____________	$____________
Non-covered medications (monthly est.)	$____________	$____________	$____________
Basic Living Expenses			
Food	$____________	$____________	$____________
Entertainment and 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 17. HEALTH AND LTC INSURANCE

Use back of form if necessary

If either and/or both individual(s) have 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 Number	Type of Policy	Monthly Premium	If Long-Term Care Ins, daily benefit
____________ # ____________	____________	$____________	$____________
____________ # ____________	____________	$____________	$____________
____________ # ____________	____________	$____________	$____________
____________ # ____________	____________	$____________	$____________
____________ # ____________	____________	$____________	$____________

SECTION 18. PLANNING AND OTHER DOCUMENTS

(Please provide us with a copy of each document)

				Date Executed Husband/Male	Date Executed Wife/Female
Wills	Have originals?	Y _____	N _____	____________	____________
	Copies?	Y _____	N _____	____________	____________
Durable Power Of Attorney	Have originals?	Y _____	N _____	____________	____________
	Copies?	Y _____	N _____	____________	____________
Health Care Proxy	Have originals?	Y _____	N _____	____________	____________
	Copies?	Y _____	N _____	____________	____________
Living Will	Have originals?	Y _____	N _____	____________	____________
	Copies?	Y _____	N _____	____________	____________
Trusts (Revocable)	Have originals?	Y _____	N _____	____________	____________
	Copies?	Y _____	N _____	____________	____________
Trusts (Other)	Have originals?	Y _____	N _____	____________	____________
	Copies?	Y _____	N _____	____________	____________

SECTION 19. TRANSFERS WITHIN 36 MONTHS

Has the individual(s) transferred property to someone other than his or her spouse within the past thirty-six (36) months?

Husband (or Single Male): If so, please provide the following information:

Recipient	Amount	Date
	$	
	$	
	$	

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

Wife (or Single Female): If so, please provide the following information:

Recipient	Amount	Date
	$	
	$	
	$	

Gift tax returns filed? ***(Please provide copies, if available)*** Yes _____ No _____

SECTION 20. 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?

Husband (or Single Male): Yes _____ No _____
Wife (or Single Female): Yes _____ No _____

If so, please provide the following information:

Name of Trust	Amount	Date
	$	
	$	

SECTION 21. GOALS OF CLIENT

Statement of goals: ____

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