



**LONG-TERM CARE PLANNING QUESTIONNAIRE (SINGLE)**

This form is extremely important. Your accuracy and completeness in responding will help represent you. Please bring this completed information packet, including each of the attached schedules, to your initial consultation.

Date: \_\_\_\_\_ File No.: \_\_\_\_\_

**A. CLIENT DATA**

**CLIENT**

Full Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Business Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

U.S. Citizen?     Yes     No                      Veteran?     Yes     No

If not a Veteran, was your former spouse a Veteran?                       Yes     No

If yes, please list branch and dates of service: \_\_\_\_\_

If widowed, or divorced, please provide name of former spouse(s): \_\_\_\_\_

**B. MEDICAL DATA**

Diagnosis: \_\_\_\_\_ Physician: \_\_\_\_\_

**C. IS CLIENT CURRENTLY RECEIVING LONG-TERM CARE SERVICES?**

Name of Facility/Caregiver/Provider: \_\_\_\_\_ Date of Onset of Care: \_\_\_\_\_

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

Business Phone: \_\_\_\_\_ Administrator or Contact: \_\_\_\_\_

**FOR FACILITY LEVEL CARE**

Date entered facility/care: \_\_\_\_\_

Medicare coverage ended/will end: \_\_\_\_\_

The facility is paid through: \_\_\_\_\_

**D. CHILDREN** (if applicable, include adult and minor children, as well as any who have predeceased you)

**NAME OF CHILD:** \_\_\_\_\_

Male                       Female                                       Married                       Single

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Relationship to Client:     Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

Relationship to Co-Client:  Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

**NAME OF CHILD:** \_\_\_\_\_

Male                       Female                                       Married                       Single

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Relationship to Client:     Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

Relationship to Co-Client:  Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

**NAME OF CHILD:** \_\_\_\_\_

Male                       Female                                       Married                       Single

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Relationship to Client:     Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

Relationship to Co-Client:  Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

**NAME OF CHILD:** \_\_\_\_\_

Male                       Female                                       Married                       Single

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Relationship to Client:     Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

Relationship to Co-Client:  Natural child    Adopted    Stepchild    Child born out of wedlock    Deceased

**Please check this box and attach a separate page to list additional children.**

**CHILDREN (continued)**

**Are all of your children in good health?**

- Yes                       No

**Are any of your children blind?**

- Yes                       No

**Are any of your children disabled?**

- Yes                       No

**Are any of your children receiving Supplemental Security Income or SSDI?**

- Yes                       No

**If yes, how much is the child's monthly payment?**

\$ \_\_\_\_\_

**Are any of your children receiving Medicaid or Medicare?**

- Medicaid                       Medicare

**Do any of your children have any problems with:**

Serious physical or mental illness?

- Yes                       No

Drug Addiction?

- Yes                       No

Alcoholism?

- Yes                       No

Debt problems/ bankruptcy?

- Yes                       No

Marital Difficulty?

- Yes                       No

If you answered yes above, please list the name and reason for listing that child.

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Do any of your children owe you money, or have you made gifts to one or more of your children that you wish to treat as an advancement of their inheritance? If yes, please provide information:

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**E. GRANDCHILDREN** (if applicable)

**NAME OF GRANDCHILD:** \_\_\_\_\_

Male                       Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name(s) of Grandchild's Parent(s): \_\_\_\_\_

Is this grandchild a direct descendant (natural or adopted) child of your child?    Yes       No

**NAME OF GRANDCHILD:** \_\_\_\_\_

Male                       Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name(s) of Grandchild's Parent(s): \_\_\_\_\_

Is this grandchild a direct descendant (natural or adopted) child of your child?    Yes       No

**NAME OF GRANDCHILD:** \_\_\_\_\_

Male                       Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name(s) of Grandchild's Parent(s): \_\_\_\_\_

Is this grandchild a direct descendant (natural or adopted) child of your child?    Yes       No

**NAME OF GRANDCHILD:** \_\_\_\_\_

Male                       Female

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name(s) of Grandchild's Parent(s): \_\_\_\_\_

Is this grandchild a direct descendant (natural or adopted) child of your child?    Yes       No

Please check this box and attach a separate page to list additional grandchildren.

**GRANDCHILDREN (continued)**

Are all of your grandchildren in good health?

Yes  No

Are any of your grandchildren blind?

Yes  No

Are any of your grandchildren disabled?

Yes  No

Are any of your grandchildren receiving Supplemental Security Income or SSDI?

Yes  No

If yes, how much is the grandchild's monthly payment?

\$ \_\_\_\_\_

Are the grandchildren receiving Medicaid or Medicare?

Medicaid  Medicare

Do any of your grandchildren have any problems with:

Serious physical or mental illness?

Yes  No

Drug Addiction?

Yes  No

Alcoholism?

Yes  No

Debt problems/ bankruptcy?

Yes  No

Marital Difficulty?

Yes  No

If you answered yes above, please list the name and reason for listing that grandchild.

\_\_\_\_\_

**F. GIFTS**

Have you made any gifts within the last 60 months?  Yes  No

Recipient: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Recipient: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Recipient: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Recipient: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Recipient: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Recipient: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Recipient: \_\_\_\_\_ Date: \_\_\_\_\_ Amount: \$ \_\_\_\_\_

Have you ever filed a Federal Gift Tax Return?  Yes  No

If yes, for what calendar years? \_\_\_\_\_

If yes, please provide a copy of the Gift Tax Return.

**G. LONG TERM CARE INSURANCE**

Do you have Long Term Care Insurance?  Yes  No

If yes, please provide a copy of the policy.

**H. MISCELLANEOUS**

Do you have any other legal issues I should be aware of?  Yes  No

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

Where do you store your important papers? \_\_\_\_\_

Do you have a Safe Deposit Box?  Yes  No

If yes, please indicate the name and address of the bank: \_\_\_\_\_

Have you prepaid your burial and funeral arrangements?  Yes  No

If yes, please provide copies of your cemetery deed and funeral contract.

Is anyone in your immediate or extended family disabled (including any spouses of your children)?

Yes  No

If yes, name and relationship of disabled family member: \_\_\_\_\_

Are there any difficult family dynamics that could impact your planning?  Yes  No

If yes, please provide information: \_\_\_\_\_

Are you a contributor to a 529 Plan?  Yes  No

If yes, please attach a statement of the 529 account.

**I. REFERRAL**

Who referred you to our office?

Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Have you visited our website at [www.AndersonElderLaw.com](http://www.AndersonElderLaw.com)?  Yes  No

Do you have any ideas for improving our website? If so, please discuss: \_\_\_\_\_

**J. CERTIFICATION**

The undersigned hereby represents to Summers Legal, PA that the information contained in this questionnaire (including the attached schedules) is accurate and complete, and that the undersigned understands that the law firm will rely on this information. If the information contained herein is inaccurate or incomplete, the recommendations made by Summers Legal, PA may not be appropriate.

\_\_\_\_\_  
*Signature of Client or Client Representative*

\_\_\_\_\_  
*Date*

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**SCHEDULE 1. FINANCIAL SUMMARY**

**PART ONE: 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 (GROSS)**

*(List only items of recurring income. Do not include interest and dividend income on this part of the form.)*

**Client**

1. Social Security Benefits: \$ \_\_\_\_\_

2. Retirement/Pension\*\*: \$ \_\_\_\_\_

\*\*Will this pension amount increase in the future?  Yes  No

**Client**

3. Veterans' Disability: \$ \_\_\_\_\_

4. Annuity Income: \$ \_\_\_\_\_

5. Rental Income: \$ \_\_\_\_\_

6. Other Income: \$ \_\_\_\_\_

7. \_\_\_\_\_: \$ \_\_\_\_\_

8. \_\_\_\_\_: \$ \_\_\_\_\_

9. \_\_\_\_\_: \$ \_\_\_\_\_

10. \_\_\_\_\_: \$ \_\_\_\_\_

**B. NON-FIXED MONTHLY INCOME**

**Client**

1. Interest: \$ \_\_\_\_\_

2. Dividends: \$ \_\_\_\_\_

3. \_\_\_\_\_: \$ \_\_\_\_\_

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

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

6. \_\_\_\_\_: \$ \_\_\_\_\_

7. \_\_\_\_\_: \$ \_\_\_\_\_

**TOTALS (A thru B):** \$ \_\_\_\_\_



**PART TWO: EXPENSES**

**A. MONTHLY SHELTER EXPENSES (Exact amounts are important)**

(Please divide annual expenses by 12, and quarterly expenses by 3)

Mortgage/Rent (include maintenance fees)	\$ _____
Real Estate Taxes	\$ _____
Water	\$ _____
Sewer	\$ _____
Utilities - Heat, Electric, and Telephone	\$ _____
Homeowners Insurance Premium	\$ _____
Condominium Fees	\$ _____
<b>Total Monthly Housing Expenses</b>	<b>\$ _____</b>

**B. MONTHLY NON-SHELTER LIVING EXPENSES (Estimates are fine)**

Food	\$ _____
Clothing	\$ _____
Transportation (including auto insurance)	\$ _____
Home Maintenance	\$ _____
Life Insurance Premiums	\$ _____
Cable TV	\$ _____
Federal and State Income Taxes	\$ _____
Entertainment and Travel	\$ _____
Support for Children	\$ _____
Long-Term Care Insurance Premiums	\$ _____
Other	\$ _____
<b>Total Monthly Non-Shelter Living Expenses</b>	<b>\$ _____</b>

**PART THREE: DEFERRED EXPENSES**

Real Estate Taxes	\$ _____
Unpaid Medical Expenses	\$ _____
Home Repairs	\$ _____
Replacement of Automobile	\$ _____

**UNREIMBURSED RECURRING MEDICAL EXPENSES (ESTIMATES ARE FINE)**

MONTHLY MEDICAL EXPENSES	CLIENT EXPENSES
Medicare (Part B)	
Medicare (Part C) or Supplemental Insurance	
Medicare (Part D) or Prescription Drug Insurance	
Prescriptions	
Nursing Home, or Assisted Living Care	
Home Health Care	
Incontinence Supplies	
Other	
Other	
Other	
Other	
Other	

**PART FOUR: ASSETS AND RESOURCES**

**A. 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 <i>(Sample)</i>	\$ xxx,xxx.xx	\$ xxx,xxx.xx	\$ xx,xxx.xx	Joint tenant
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**B. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)**

(Please provide copies of most recent 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. <i>(Sample)</i>	xxx-xxxx	Savings	\$ xx,xxx.xx	Jointly w/ son
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____

**C. SECURITIES (Bonds, Marketable Securities, etc.)**

(Please provide copies of most recent 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. <i>(Sample)</i>	Common <i>(or Preferred)</i>	xx Shares	\$ x,xxx.xx	\$ x,xxx.xx	Sole owner
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____

**D. RETIREMENT ACCOUNTS (IRAs, Annuities, Keoghs, etc.)**

(Please provide copies of most recent statements and beneficiary designations)

<b>Name of Institution</b>	<b>Account No.</b>	<b>Owner</b>	<b>Beneficiary</b>	<b>Date Est.</b>	<b>Current Value</b>
Big Broker <i>(Sample)</i>	xxx-xxxx	Client	Son/Daughter	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

**E. LIFE INSURANCE (Whole Life, Term, Endowment, etc.)**

(Please provide copies of most recent statements and beneficiary designations)

<b>Name of Institution</b>	<b>Account No.</b>	<b>Owner</b>	<b>Beneficiary</b>	<b>Date Est.</b>	<b>Current Value</b>
Apple Ins. Co. <i>(Sample)</i>	xxx-xxxx	Client	Son/Daughter	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

**F. PERSONAL PROPERTY**

	<b>Market Value and Item</b>	<b>How Title Held</b>
Home Furnishings:	\$ _____	_____
Cars, RVs, Boats, etc.:	\$ _____	_____
Cars, RVs, Boats, etc.:	\$ _____	_____
Cars, RVs, Boats, etc.:	\$ _____	_____
Jewelry , Furs, etc.:	\$ _____	_____
Other :	\$ _____	_____
Other :	\$ _____	_____

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

Briefly describe or give the name of any Trust in which you have an interest, or the person who is the source of the inheritance and what you expect to receive. Please provide a copy of the Will or Trust which creates the interest, if available. If not, please advise if and how we may obtain a copy.

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**I. BUSINESS INTERESTS**

If client has an ownership in any business (whether sole proprietorship, corporation or partnership), please provide additional information regarding the nature of the interest and value of the business interest. If there are business documents (such as Buy-Sell Agreements, Stock Certificates, etc.) please provide copies.

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**J. MISCELLANEOUS**

If client has any property interests not described above, please explain the nature of the interests and the estimated value of each.

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**SCHEDULE 2. – SELECTING BENEFICIARIES**

Please note we will spend time during our first meeting completing Schedule 2 and Schedule 3. However, you may want to review your existing documents (if any) and the following choices of beneficiaries and fiduciaries in preparation for our meeting.

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. Are there certain items of personal property that should pass to designated individuals? Are there specific charities or individuals that you intend to leave a gift? Are some selected beneficiaries going to require a Trustee to manage their fund on their behalf?

A. First-choice beneficiaries:       Children    Other

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B. Second-choice beneficiaries:    Children    Other

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C. Third-choice beneficiaries:       Children    Other

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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 other household and/or personal effects?

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

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**SCHEDULE 3. – SELECTING FIDUCIARIES**

(Please provide names, addresses and phone numbers if chosen person is not a child or grandchild.)

**POSITION** \_\_\_\_\_ **CLIENT** \_\_\_\_\_

**WILL SELECTIONS:**

Executor or Co-Executors \_\_\_\_\_

1st Successor(s) \_\_\_\_\_

2nd Successor(s) \_\_\_\_\_

Trustee or Co-Trustees \_\_\_\_\_

Guardian(s) for minor of disabled Children \_\_\_\_\_

**FINANCIAL GENERAL POWER OF ATTORNEY:**

Agent or Co-Agents \_\_\_\_\_

1st Successor(s) \_\_\_\_\_

2nd Successor(s) \_\_\_\_\_

If more than one Agent is selected, may either Agent act alone, independently of the other Agent, or must all Co-Agents act together?

Yes, my Co-Agents may act independently of each other.  No, each task must be undertaken jointly by all Co-Agents

**HEALTH CARE POWER OF ATTORNEY & LIVING WILL:**

Agent or Co-Agents \_\_\_\_\_

1st Successor(s) \_\_\_\_\_

2nd Successor(s) \_\_\_\_\_

If more than one Agent is selected, may either Agent act alone, independently of the other Agent, or must all Co-Agents act together?

Yes, my Co-Agents may act independently of each other.  No, each task must be undertaken jointly by all Co-Agents

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