LONG-TERM CARE PLANNING QUESTIONNAIRE (COUPLE)

This form is extremely important. Your accuracy and completeness in responding will help us 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: ______________________
Date of Birth: ______________________
Social Security Number: ______________________
E-mail Address: ______________________
Cell Phone Number: ______________________
Business Phone Number: ______________________
U.S. Citizen? O Yes O No
Veteran? O Yes O No
If yes, please list branch and dates of service:
____

CO-CLIENT

Full Name: ______________________
Street Address: ______________________
City: ______________________
State: ______________________
Zip: ______________________
Home Phone: ______________________
Date of Birth: ______________________
Social Security Number: ______________________
E-mail Address: ______________________
Cell Phone Number: ______________________
Business Phone Number: ______________________
U.S. Citizen? O Yes O No
Veteran? O Yes O No
If yes, please list branch and dates of service:
____

B. MARITAL INFORMATION

Date of Marriage: ______________________
Place of Marriage: ______________________
City: ______________________ State or Province: __________ Country: __________

C. MEDICAL DATA

NAME OF ILL CLIENT: ______________________________

Diagnosis: ______________________________

Physician: ______________________________

(Physician's name and contact information, if available.)

NAME OF WELL CLIENT: ______________________________

Diagnosis: ______________________________

Physician: ______________________________

(Physician's name and contact information, if available.)

D. 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: ______________________________

(month/day/year)

Medicare coverage ended/will end: ______________________________

(month/day/year)

The facility is paid through: ______________________________

(month/day/year)

E. IS CO-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: ______________________________

(month/day/year)

Medicare coverage ended/will end: ______________________________

(month/day/year)

The facility is paid through: ______________________________

(month/day/year)

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

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ____________________ Cell Phone Number: ____________________

Date of Birth: ____________________ E-mail Address: ____________________

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

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

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ____________________ Cell Phone Number: ____________________

Date of Birth: ____________________ E-mail Address: ____________________

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

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

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ____________________ Cell Phone Number: ____________________

Date of Birth: ____________________ E-mail Address: ____________________

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

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

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ____________________ Cell Phone Number: ____________________

Date of Birth: ____________________ E-mail Address: ____________________

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

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

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

CHILDREN (continued)

Are all of your children in good health?
O Yes O No

Are any of your children blind?
O Yes O No

Are any of your children disabled?
O Yes O No

Are any of your children receiving Supplemental Security Income or SSDI?
O Yes O No

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

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

Do any of your children have any problems with:

Serious physical or mental illness?
O Yes O No

Drug Addiction?
O Yes O No

Alcoholism?
O Yes O No

Debt problems/ bankruptcy?
O Yes O No

Marital Difficulty?
O Yes O No

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

____

____

____

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:

____

____

____

G. GRANDCHILDREN (if applicable)

NAME OF GRANDCHILD: ______________________________

O Male O 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? O Yes O No

NAME OF GRANDCHILD: ______________________________

O Male O 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? O Yes O No

NAME OF GRANDCHILD: ______________________________

O Male O 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? O Yes O No

NAME OF GRANDCHILD: ______________________________

O Male O 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? O Yes O No

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

GRANDCHILDREN (continued)

Are all of your grandchildren in good health?
O Yes O No

Are any of your grandchildren blind?
O Yes O No

Are any of your grandchildren disabled?
O Yes O No

Are any of your grandchildren receiving Supplemental Security Income or SSDI?
O Yes O No

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

Are the grandchildren receiving Medicaid or Medicare?
O Medicaid O Medicare

Do any of your grandchildren have any problems with:

Serious physical or mental illness?
O Yes O No

Drug Addiction?
O Yes O No

Alcoholism?
O Yes O No

Debt problems/ bankruptcy?
O Yes O No

Marital Difficulty?
O Yes O No

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

____

H. GIFTS

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

If yes, for what calendar years? ____________________

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

I. LONG TERM CARE INSURANCE

Do you have Long Term Care Insurance? O Yes O No

If yes, please provide a copy of the policy.

J. MISCELLANEOUS

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

If yes, please explain:

____

____

Where do you store your important papers? ______________________

Does anyone in your immediate or extended family have special needs issues (including spouses of your children)? O Yes O No

If yes, name and relationship of disabled family member: ______________________

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

If yes, please provide information: ______________________

Are you a contributor to a 529 Plan? O Yes O No

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

K. 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? O Yes O No

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

L. CERTIFICATION

The undersigned hereby represents to Anderson Elder Law 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 Anderson Elder Law may not be appropriate.

______________________________________ ______________________________
Signature of Client or Client Representative *Date*

FOR INTERNAL USE ONLY
EP ______________________________ Current: ______________________________ ______________________________ Proposed: ______________________________ ______________________________ ______________________________
CP ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________
APP ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________

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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	Co-Client
1. Social Security Benefits:	$ ____________	$ ____________
2. Retirement/Pension**:	$ ____________	$ ____________
**Will this pension amount increase in the future?	O Yes O No	O Yes O No

	Client	Co-Client	Joint
3. Veterans' Disability:	$ ____________	$ ____________	$ ____________
4. Annuity Income:	$ ____________	$ ____________	$ ____________
5. Rental Income:	$ ____________	$ ____________	$ ____________
6. Other Income:	$ ____________	$ ____________	$ ____________
7. ____________:	$ ____________	$ ____________	$ ____________
8. ____________:	$ ____________	$ ____________	$ ____________
9. ____________:	$ ____________	$ ____________	$ ____________
10. ____________:	$ ____________	$ ____________	$ ____________

B. NON-FIXED MONTHLY INCOME

	Client	Co-Client	Joint
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	$ ________
Total Monthly Housing Expenses	**$** ________

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	$ ________
Total Monthly Non-Shelter Living Expenses	**$** ________

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	CO-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)

Address	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	

B. BANK AND SAVINGS ACCOUNTS (CDs, Checking, Savings, Money Market, etc.)

(Please provide copies of most recent statements)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
			$	
			$	
			$	
			$	
			$	
			$	
			$	
			$	

C. STOCKS AND BONDS

(Please provide copies of most recent statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

D. RETIREMENT ACCOUNTS (Pension (P), Profit Sharing (PS), IRA, SEP, 401(k), 403(b), etc.)

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

Name of Institution	Account No.	Owner	Beneficiary	Type	Current Value
					$
					$
					$
					$
					$
					$
					$

E. ANNUITIES

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

Name of Company	Account No.	Owner	Beneficiary	Type	Current Value
					$
					$
					$
					$
					$
					$
					$

F. LIFE INSURANCE (Whole Life, Term, Endowment, etc.)

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

Name of Insurance Co.	Policy No.	Owner	Beneficiary	Cash Value	Death Benefits
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$
				$	$

G. FUNERAL & CEMETERY ARRANGEMENTS (Prepaid)

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

Name of Company	Type of Plan	Funds Paid	Total Cost
			$
			$
			$
			$
			$

H. SAFE DEPOSIT BOXES

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

Name of Institution	Account No.	Owner	Branch Location

I. FURNITURE & PERSONAL PROPERTY

	Market Value and Item	How Title Held
Home Furnishings:	$	
Cars, RVs, Boats, etc.:	$	
Cars, RVs, Boats, etc.:	$	
Cars, RVs, Boats, etc.:	$	
Jewelry , Furs, etc.:	$	
Other :	$	
Other :	$	
Other :	$	
Other :	$	
Other :	$	
Other :	$	
Other :	$	

J. 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.

____

____

____

____

K. BUSINESS INTERESTS

If either 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.

____

____

____

____

L. LIABILITIES

Please summarize any outstanding debt in your homes

____

____

____

____

M. MISCELLANEOUS

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

____

____

____

____

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?

Please note any differences between spousal wishes.

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

____

____

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

____

____

____

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

____

____

D. Any specific disposition of your residence?

____

____

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

____

____

F. Any specific disposition of other household and/or personal effects?

____

____

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

____

____

SCHEDULE 3. – SELECTING FIDUCIARIES

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

POSITION	CLIENT	CO-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

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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