



ANDERSON ELDER LAW

ELDER LAW • ESTATE PLANNING • SPECIAL NEEDS PLANNING

LONG-TERM CARE PLANNING QUESTIONNAIRE (COUPLE)

This form is extremely important. Your accuracy and completeness in responding will help Anderson Elder Law 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? Yes No

Veteran? Yes 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? Yes No

Veteran? Yes No

If yes, please list branch and dates of service:

B. MARITAL INFORMATION

Date of Marriage: _____

Place of Marriage: _____

City: _____ State or Province: _____ Country: _____

Long-Term Care Planning Questionnaire (Couple)

206 Old State Road • Media, PA 19063 • T: 610-566-4700 • F: 610-566-4702

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: _____

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.

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: _____

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.

H. 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.

I. LONG TERM CARE INSURANCE

Do you have Long Term Care Insurance? Yes No

If yes, please provide a copy of the policy.

J. 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? _____

Does anyone in your immediate or extended family have special needs issues (including 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.

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? Yes 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? Yes No Yes 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)

<u>Address</u>	<u>Cost (Basis)</u>	<u>Market Value</u>	<u>Mortgage Bal.</u>	<u>How Title Held</u>
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	\$ _____	_____

B. BANK AND SAVINGS ACCOUNTS (CDs, Checking, Savings, Money Market, 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>
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____

C. STOCKS AND BONDS

(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>
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____

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)

<u>Name of Company</u>	<u>Type of Plan</u>	<u>Funds Paid</u>	<u>Total Cost</u>
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

H. SAFE DEPOSIT BOXES

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

<u>Name of Institution</u>	<u>Account No.</u>	<u>Owner</u>	<u>Branch Location</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I. FURNITURE & PERSONAL PROPERTY

	<u>Market Value and Item</u>	<u>How Title Held</u>
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: 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?

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

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