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CONFIDENTIAL ESTATE AND 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.

Please PRINT and use blue or black ink

DATE: _____ Referred By: _____

SECTION 1. NAME AND CONTACT INFORMATION

Client's Full Name: _____
(first) (middle) (last)

Spouse's Full Name: _____
(first) (middle) (last)

Email Address: _____

Home Address: _____

_____

	Client	**Spouse**
Telephone Numbers:	_____ (home)	_____ (home)
	_____ (cell)	_____ (cell)
Date of Birth:	_____	_____
Former/Maiden Names:	_____	_____
US Citizen?:	[ ] Yes [ ] No	[ ] Yes [ ] No

Social Security Number: _____ _____

Military Service: _____ _____

Date of Death: _____ _____

SECTION 2. MARITAL INFORMATION

A. Date of Marriage: _____

B. Place of Marriage: _____
(city) (state or province) (country)

(Please attach a copy of Certificate)

C. Client's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

D. Spouse's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

SECTION 3. CHILDREN

List all children. Copy and attach additional pages, if needed. Total number of children: _____

1. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____
(current address)

H:_____ C:_____
(home phone number) (cell phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

Disabled [ ] Yes [ ] No

2. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____
(current address)

H:_____ C:_____
(home phone number) (cell phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

Disabled [ ] Yes [ ] No

3. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____
(current address)

H:_____ C:_____
(home phone number) (cell phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

Disabled [ ] Yes [ ] No

4. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____
(current address)

H:_____ C:_____
(home phone number) (cell phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

Disabled [ ] Yes [ ] No

5. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____
(current address)

H:_____ C:_____
(home phone number) (cell phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

Disabled [ ] Yes [ ] No

SECTION 4. ESTATE PLANNING

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. ***Please note that we expect that this will be completed during our first conference with you regarding estate planning. You may want to use this section as items to consider before our conference.***

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

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 gifts of household and personal effects?

_____

_____

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

_____

_____

SECTION 5. FIDUCIARIES

Please consider who you want to handle your affairs when you cannot. ***We will discuss this section at our conference.***

A. EXECUTORS (Co-Executors Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

_____ _____
(current address) (phone number)

B. TRUSTEES (Co-Trustees Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

_____ _____
(current address) (phone number)

C. GUARDIANS OF MINOR CHILDREN (Co-Guardians Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [ ] Yes [ ] No)
or [ ] Successor Guardian

_____ _____
(current address) (phone number)

D. AGENTS UNDER POWER OF ATTORNEY (Co-Agents Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

_____ _____
(current address) (phone number)

E. AGENTS UNDER HEALTH CARE PROXY

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

SECTION 6. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

_____

_____

_____

B. Spouse

_____

_____

_____

SECTION 7. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: [ ] Yes [ ] No

Spouse: [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

B. OTHER ISSUES

	Client	Spouse
Able to sign name?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to speak?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to recognize friends and family?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Cognizant of property and possessions?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to leave current residence?:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 8. NURSING HOME INFORMATION

A. Client

Currently in facility? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

B. Spouse

Currently in a facility? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

SECTION 9. HOSPITAL

A. Client

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is nursing home placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

B. Spouse

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is nursing home placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

SECTION 10. 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

		Client	Spouse	Joint
1.	Social Security:	$ _____	$ _____	$ _____
2.	Annuity:	$ _____	$ _____	$ _____
3.	Pension:	$ _____	$ _____	$ _____
4.	_____:	$ _____	$ _____	$ _____
5.	_____:	$ _____	$ _____	$ _____

B. NON-FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Interest:	$ _____	$ _____	$ _____
2.	Dividends:	$ _____	$ _____	$ _____
3.	Rent income:	$ _____	$ _____	$ _____
4.	_____:	$ _____	$ _____	$ _____
5.	_____:	$ _____	$ _____	$ _____
C.	**TOTALS (A thru B):**	**$** _____	**$** _____	**$** _____

D. Tax Preparer/Accountant Information:

Company:_____

Name:_____

Address:_____

Phone Number:_____

E. Financial Advisor Information:

Company:_____

Name:_____

Address:_____

Phone Number:_____

SECTION 11. ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)
Please provide copies of most recent statements

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. **(Sample)**	*123-45-6789*	*Savings*	*$ 85,321.87*	*Jointly w/ son*
			$	
			$	
			$	
			$	
			$	

B. SECURITIES (Bonds, Marketable Securities, etc.)
(Please provide copies of statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. **(Sample)**	*Common* (or Preferred)	*100 Shares*	*$ 5000*	*$ 9000*	*Sole owner*
			$	$	
			$	$	
			$	$	

			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)
(Please provide copies of statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker (Sample)	*123-45-678*	*Client*	*Spouse*	*Jan, 1970*	*$ 85,000.00*
					$
					$
					$
					$
					$

D. LIFE INSURANCE POLICIES
(Please provide copies of MOST RECENT policy statements and beneficiary designations, etc.)

Name of Company & Policy Number	Owner	Insured	Bene.	Death Value	Cash Value
MetLife: 123-45-678 (Sample)	*Client*	*Spouse*	*Child*	*$ 5,000.00*	*$ 5,000.00*
				$	$
				$	$
				$	$
				$	$
				$	$

E. REAL ESTATE
(Please provide copies of DEEDS and most recent TAX BILLS)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
123 Know Way (Sample)	*$ 120,000*	*$ 180,000*	*$ 85,321.87*	*Joint tenant*
	$	$	$	

_____	$_____	$_____	$_____	_____
_____	$_____	$_____	$_____	_____
_____	$_____	$_____	$_____	_____
_____	$_____	$_____	$_____	_____

HOMEOWNER'S INSURANCE INFORMATION:

Agent Name and Address: _____

Insurance Company Name: _____

Policy Number: _____

F. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$_____	_____
Cars:	$_____	_____
Jewels, Furs, etc.:	$_____	_____
RVs, Boats, etc.:	$_____	_____

G. 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.). Please bring a copy of any agreements, financial statements, etc.

_____

_____

_____

H. PROSPECTIVE INHERITANCES OR RIGHTS OR INTERESTS IN TRUSTS, ESTATES

Briefly describe or give the name of the Trust in which the person 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.

_____

_____

SECTION 12. FUNERAL/BURIAL INFORMATION

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 person needing care has the listed items.

	Client	Spouse
Burial plot:	[ ] Yes [ ] No	[ ] Yes [ ] No
Irrevocable burial fund contract:	[ ] Yes [ ] No	[ ] Yes [ ] No
Funeral Home:	_____	

SECTION 13. MEDICAL EXPENSES

A. MEDICAL EXPENSES (ESTIMATED PER MONTH)

	Client	Spouse	Joint
1. Non-covered medications:	$_____	$_____	$_____
2. _____: (specify)	$_____	$_____	$_____
3. _____: (specify)	$_____	$_____	$_____

SECTION 14. HEALTH AND LTC INSURANCE

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
Acme Insurance **(Sample)**	*123-45-6789*	*Long-term care*	*$ 3,000*	*$ 300.00 per day*
_____	_____	_____	$_____	$_____
_____	_____	_____	$_____	$_____
_____	_____	_____	$_____	$_____
_____	_____	_____	$_____	$_____

SECTION 15. PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	Client	Spouse
Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No	[ ] Yes [ ] No
Pour-Over Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Health Care Power of Attorney (or Proxy):	[ ] Yes [ ] No	[ ] Yes [ ] No
Living Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No	[ ] Yes [ ] No

(specify)

SECTION 16. GIFTS WITHIN 60 MONTHS

Has the person needing care transferred property to someone other than his or her spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**:

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

SECTION 17. TRANSFERS TO OR FROM TRUSTS

Has the person needing care transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

SECTION 18. CLIENT'S GOALS

What are your goals?

_____

_____

_____

_____

_____

_____

_____

*****REMINDER: For accuracy and efficiency, please provide copies of most recent deeds, tax bills, life insurance policies, annuities and for any and all other accounts you may have.*****