

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

This form is extremely important. Your accuracy and completeness in responding will help me represent you. Bring this information with you to our appointment.

Date: _____ File No.: _____

Home Phone No.: _____ Business Phone No.: _____

Cell Phone No.: _____ Fax No.: _____

E-mail Address: _____

A. CLIENT DATAFull Name: _____
(print name as shown on your checks)

Street Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security No.: _____

U.S. Citizen? Yes NoIf widowed, please list **name of spouse** and **date of death**: _____Was your former spouse a Veteran? Yes NoIf you or your former spouse is or was a Veteran, are you receiving Tricare? Yes No**B. MEDICAL DATA****1. HEALTH**

Diagnosis: _____

If you live in a nursing home: _____

Name of Nursing Home: _____

Date Entered: _____

2. PHYSICIAN

Full Name of Primary Physician: _____

Street Address: _____

City: _____ State: _____ Zip: _____

3. PHARMACEUTICAL PLANS

If you are a Pennsylvania resident, are you currently on PACE/PACENET? Yes No

If you are a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? Yes No

C. MONTHLY INCOME

Social Security Benefits \$ _____

Medicare Part B Deduction \$ 96.40
122.20
160.90
199.70
238.40

Co-pay for Medicare Part D (if applicable) \$ _____

Retirement Benefits (Gross) \$ _____

Veterans Disability Income \$ _____

Annuity Income \$ _____

Rental Income \$ _____

TOTAL MONTHLY INCOME \$ _____

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

Do not include interest and dividend income on this form.

D. GIFTS

Have you made any gifts within the last five years? Yes No

If yes, list below:

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, please state details: _____

E. CHILDREN (if applicable, include adult and minor children)**Name of Child:** _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Work Phone No.: _____

Date of Birth: _____ Social Security Number: _____

E-mail Address: _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlockRelationship to Wife: Natural child Adopted Stepchild Child born out of wedlock**Name of Child:** _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Work Phone No.: _____

Date of Birth: _____ Social Security Number: _____

E-mail Address: _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlockRelationship to Wife: Natural child Adopted Stepchild Child born out of wedlock**Name of Child:** _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Work Phone No.: _____

Date of Birth: _____ Social Security Number: _____

E-mail Address: _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlockRelationship to Wife: Natural child Adopted Stepchild Child born out of wedlock

Name of Child: _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Work Phone No.: _____

Date of Birth: _____ Social Security Number: _____

E-mail Address: _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlockRelationship to Wife: Natural child Adopted Stepchild Child born out of wedlockAre all your children in good health? Yes NoAre any of your children blind? Yes NoAre any of your children disabled? Yes NoAre any of your children receiving SSI or other form
of government entitlement? Yes No

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

Is the child receiving Medicaid or Medicare Medicaid Medicare

Do any of your family members have any problems with:

AIDS? Yes NoDrug Addiction? Yes NoAlcoholism? Yes NoSpendthrift? Yes NoMarital Difficulty? Yes NoDo any of your children live in your home? Yes No

If yes, name of child(ren): _____

Are you a contributor to a 529 Plan? Yes No

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

F. CONTACT INFORMATION

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Fax No.: _____

E-mail Address: _____ Cell No.: _____

I. MISCELLANEOUS

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

If yes, please explain: _____

J. REFERRAL

By whom were you referred to this office?

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone No.: _____ Fax No.: _____

E-mail Address: _____ Cell No.: _____

Referral is: Attorney Financial Planner Previous Client of Anderson Elder Law

Doctor Social Worker Other: _____

Have you visited our Website at www.AndersonElderLaw.com? Yes No

Do you have any ideas for improving our Website? If so, please discuss.

K. CERTIFICATION

The undersigned hereby represents to Anderson Elder that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Person Preparing Form

Date

Signature of Client or Client Representative: _____

LONG-TERM CARE PLANNING - ADDITIONAL INFORMATION

Last Name of Client: _____ File No.: _____

A. ASSETS/LIABILITIES

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING		
SAVINGS		
MONEY MARKET		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) Folio No: _____ Assessed Value: _____		
OTHER REAL ESTATE Folio No: _____ Assessed Value: _____		

ASSETS/LIABILITIES CONT'D.

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
AUTOMOBILE(S)		
BROKERAGE/CAP ACCOUNTS		
MUTUAL FUNDS		
STOCKS		
BONDS		
TRADITIONAL IRA/RETIREMENT PLANS		
ROTH IRA		
NURSING HOME DEPOSIT		
PREPAID FUNERAL		
OTHER:		
OTHER:		
OTHER:		
TOTAL		

What did you pay for your current home, including improvements? \$ _____

Address of any real property other than personal residence:

(1) Street: _____ City: _____ State: _____ Zip: _____

Folio No.: _____ (Can be obtained from Tax Bill)

What did you pay for this property, including improvements? \$ _____

(2) Street: _____ City: _____ State: _____ Zip: _____

Folio No.: _____ (Can be obtained from Tax Bill)

What did you pay for this property, including improvements? \$ _____

Name of Homeowner's Insurance Company: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone No.: _____ Policy No.: _____

B. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost: \$ _____

Monthly Prescription Cost: \$ _____

Monthly Incontinent Cost: \$ _____

Monthly Medical Insurance Cost: \$ _____

Other Monthly Costs: \$ _____

Total Monthly Cost: \$ _____

The Nursing Home is paid through _____ (month/year).

C. LIFE INSURANCE**Name of Insurance Company:** _____ **Policy #:** _____

Street Address: _____

City: _____ State: _____ Zip: _____

Type of Policy: _____ Owner: _____

Insured: _____ Beneficiary: _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____



Name of Insurance Company: _____ **Policy #:** _____

Street Address: _____

City: _____ State: _____ Zip: _____

Type of Policy: _____ Owner: _____

Insured: _____ Beneficiary: _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company: _____ **Policy #:** _____

Street Address: _____

City: _____ State: _____ Zip: _____

Type of Policy: _____ Owner: _____

Insured: _____ Beneficiary: _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company: _____ **Policy #:** _____

Street Address: _____

City: _____ State: _____ Zip: _____

Type of Policy: _____ Owner: _____

Insured: _____ Beneficiary: _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company: _____ **Policy #:** _____

Street Address: _____

City: _____ State: _____ Zip: _____

Type of Policy: _____ Owner: _____

Insured: _____ Beneficiary: _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____