



ANDERSON ELDER LAW

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

LONG-TERM CARE PLANNING QUESTIONNAIRE (MARRIED)

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.: _____

A. CLIENT DATA

HUSBAND

WIFE

Full Name: _____ Full Name: _____
(print name as shown on your checks) (print name as shown on your checks)

Street Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Birth Date: _____

Social Security No.: _____ Social Security No.: _____

Home Phone: _____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Business Phone: _____ Business Phone: _____

Fax Number: _____ Fax Number: _____

Email: _____ Email: _____

U.S. Citizen? Yes No

U.S. Citizen? Yes No

Veteran? Yes No If yes, receive Tricare? Veteran? Yes No If yes, receive Tricare?

B. MEDICAL DATA

1. HEALTH

Name of Ill Spouse: _____

Diagnosis: _____

If Ill Spouse has entered a nursing home:

Name of Nursing Home: _____

Date Entered: _____

Name of Well Spouse: _____

Health of Well Spouse: _____



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2. PHYSICIAN

Full Name of Husband's Primary Physician: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Full Name of Wife's Primary Physician: _____

Street Address: _____

City: _____ State: _____ Zip: _____

3. STATE PHARMACEUTICAL PLANS

If you are a Pennsylvania resident, are you currently receiving benefits under PACE / PACE NET? Yes No

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

If yes: _____

C. MONTHLY INCOME*

	HUSBAND	WIFE
Social Security Benefits (Gross amount) \$	\$ _____	\$ _____
Medicare Part B Deduction*	\$96.40	\$96.40
	\$110.50	\$110.50
	\$115.40	\$115.40
	\$161.50	\$161.50
	\$230.70	\$230.70
	\$299.90	\$299.90
	\$369.10	\$369.10

* If married, but separated, lower premium amounts will apply.

Retirement Benefits (Gross Amount) \$ _____ \$ _____

VA Disability Compensation (Rated Disability ___%) \$ _____ \$ _____

VA Disability Pension (A+A, Home Bond, Basic) \$ _____ \$ _____

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 part of the form.**



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MONTHLY COST OF FACILITY OR OTHER CARE EXPENSES

Monthly Facility Cost: \$ _____

Monthly Home Healthcare 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)

LONG-TERM CARE INSURANCE?

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

Street Address _____

Owner _____

Daily Benefit _____

Elimination Period _____

D. MONTHLY SHELTER EXPENSES (Exact amounts are important) (Please divide annual expenses by 12, and quarterly expenses by 3).

Rent/Mortgage \$ _____

Real Estate Taxes \$ _____

Water \$ _____

Sewer \$ _____

Utilities (Heat, Electric, and Telephone)
(1/12th of last 12 months) \$ _____

Homeowner's insurance premium \$ _____

Condominium fees \$ _____

Total Monthly Housing Expenses \$ _____



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

Food	\$ _____
Medical	\$ _____
Clothing	\$ _____
Transportation (including auto insurance)	\$ _____
Home Maintenance	\$ _____
Life Insurance Premiums	\$ _____
Health Insurance Premiums	\$ _____
Cable TV	\$ _____
Federal and State Income Taxes	\$ _____
Other	\$ _____
Total Monthly Non-Shelter Living Expenses	\$ _____

F. GIFTS

Have you made any gifts in the last 5 years?

Yes No If yes, list below:

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: _____

G. CHILDREN (if applicable, include adult and minor children, including children who have predeceased you)

Name of Child: _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

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

E-mail Address: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

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

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



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Name of Child: _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

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

E-mail Address: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

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

Relationship 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.: _____

E-mail Address: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

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

Relationship 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.: _____

E-mail Address: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

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

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



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Are all your children in good health? Yes No If no, _____

Are any of your children blind? Yes No If yes, _____

Are any of your children disabled? Yes No If yes, _____

Are any of your children receiving SSI or other form of government entitlement? Yes No If yes, _____

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:

- Serious Physical or Mental Illness Yes No
- Drug Addiction/Alcoholism Yes No
- Spendthrift/Creditor Problems Yes No
- Marital Difficulties? Yes No

Do any of your children live in your home? Yes No

If yes, name of child: _____

Are you a contributor to a 529 Plan? Yes No

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

H. CONTACT PERSON (If someone other than client completes form).

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: _____



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J. REFERRAL: Who referred you to this office?

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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 Law 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 Client or Client Representative

Date



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L. 1. FINANCIAL SUMMARY

	<u>ASSETS</u>			<u>LIABILITIES</u>
	Husband	Wife	Joint	
Real Estate (residence; attach copy of deed)	\$	\$	\$	\$
Real Estate (other; attach copies of all deeds)	\$	\$	\$	\$
Bank Accounts (attach copies of statements)	\$	\$	\$	\$
Savings Certificates (CDs; attach copies of statements)	\$	\$	\$	\$
Stocks - Non Mutual Funds (Not Held by Broker; attach copies of all certificates)	\$	\$	\$	\$
Stocks - Non Mutual Funds (Held by Broker; attach copies of brokerage statements)	\$	\$	\$	\$
Bonds - Non Mutual Funds (Not Held by Broker; attach copies of all bonds)	\$	\$	\$	\$
Bonds - Non Mutual Funds (Held by Broker; attach copies of brokerage statements)	\$	\$	\$	\$
Mutual Funds (attach copies of statements)	\$	\$	\$	\$
Note and Mortgage Receivables (attach copies of Notes and Mortgages)	\$	\$	\$	\$



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FINANCIAL SUMMARY – Cont'd.

	<u>ASSETS</u>			<u>LIABILITIES</u>
	Husband	Wife	Joint	
Business Interests (attach copies of stock certificates, partnership agreements, and/or other documentation)	\$	\$	\$	\$
Inheritance, etc.	\$	\$	\$	\$
Automobiles	\$	\$	\$	\$
Jewelry and Collections	\$	\$	\$	\$
IRAs (attach copies of statements)	\$	\$	\$	\$
Tax Qualified (Non-IRA) Retirement Plans (attach copies of statements)	\$	\$	\$	\$
Life Insurance (attach copies of all policies)	\$	\$	\$	\$
Annuities (attach copies of all contracts)	\$	\$	\$	\$
Other Assets (attach documentation)	\$	\$	\$	\$
Any debts?	\$	\$	\$	\$
TOTALS	\$	\$	\$	\$