ANDERSON ELDER LAW

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

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.: ______________________

A. CLIENT DATA

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

Street Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone No.: ______________________ Business Phone No.: ______________________

Cell Phone No.: ______________________ Fax No.: ______________________

E-mail Address: ____

Birth Date: ______________________ Social Security No.: ______________________

If widowed, please list **name of spouse** and **date of death:** ______________________

U.S. Citizen? ☐ Yes ☐ No

Are you a Veteran? ☐Yes ☐ No

If not, was your former spouse a Veteran? ☐Yes ☐No If yes, please provide information

If 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: __________

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3. STATE 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

If yes, ______________________________

C. MONTHLY INCOME*

Social Security Benefits (Gross amount) $ ____________________

Medicare Part B Deduction (select 1)

☐ $96.40
☐ $110.50
☐ $115.40
☐ $161.50
☐ $230.70
☐ $299.90
☐ $369.10

Retirement Benefits (Gross Amount) $ ____________________

VA Disability Compensation (Rated Disability ___%) $ ____________________

VA Disability Pension (A+A, Homebond, Basic) $ ____________________

Annuity Income $ ____________________

Rental Income $ ____________________

TOTAL MONTHLY INCOME $ ____________________

If there is a pension, please list the gross pension amount, before 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. MONTHLY COST OF FACILITY HOME OR OTHER CARE EXPENSES

Monthly Facility Cost: $ ____________________

Monthly Home Healthcare: $ ____________________

Monthly Prescription Cost: $ ____________________

Monthly Incontinent Cost: $ ____________________

Monthly Medical Insurance Cost: $ ____________________

Other Monthly Costs: $ ____________________

Total Monthly Cost: $ ____________________

The Nursing Home is paid through ____________________ (month/year)

E. LONG-TERM CARE INSURANCE?

Name of Insurance Company: ______________________________Policy # __________________________

Street Address ____

Owner ____

Daily Benefit ____

Elimination Period ____

F. 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: ____

____

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

Name of Child: ____ Male ☐ Female ☐

Street Address: ____

City: ____State:__________________ Zip: ___________________

Home Phone No.: ____________________________Work Phone No.: ______________________________

Cell Phone: _________________________________E-mail Address: ______________________________

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.: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

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.: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

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.: ______________________

Cell Phone: ______________________ E-mail Address: ______________________

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

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? ☐ Yes ☐ No

Alcoholism? ☐ Yes ☐ No

Debt problems/bankruptcy? ☐ Yes ☐ No

Marital Difficulties? ☐ Yes ☐ No

Do 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.

H. CONTACT INFORMATION (if someone other than client completed the 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: ____

____

J. REFERRAL

Who referred you to our office?

Full Name: ____

Street Address: ____

City: ______________________ State: __________ Zip: ______________

Phone No.: ______________________ Email: ______________________

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

LONG-TERM CARE PLANNING - ADDITIONAL INFORMATION

Last Name of Client: ____ File No.: _______________

L. 1. FINANCIAL SUMMARY

	ASSETS	**LIABILITIES**
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.

	ASSETS	**LIABILITIES**
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 copies of documentation)	$	$
Any debts?	$	$
TOTALS	$	$