Appointment date and time:_____

LONG TERM CARE PLANNING QUESTIONNAIRE

Please complete the following questionnaire to the best of your ability. This information is most helpful to us so that we may properly plan for you and it will be held in the strictest confidence. We will review this information at our meeting. The client is the person for whom planning is being implemented.

DO NOT BE UPSET IS YOU CANNOT COMPLETE ALL OF THE QUESTIONS.

PERSONAL INFORMATION

		Date of Birth	Soc. Sec. #
Name of Client:	_____	_____	_____
Spouse:	_____	_____	_____

Address: _____

Telephone: **Home:**_____ **Cell:** _____

Business:_____ **Email:** _____

Contact Person (if not client):_____
Name **Relationship to Client**

Address: _____

Telephone: **Home:**_____ **Cell:** _____

Business:_____ **Email:** _____

Client's Objective:_____
_____
_____

MARITAL INFORMATION

Have you been married previously?_____

If yes, please provide prior spouse's name and date of death or divorce:_____
_____

CHILDREN

Children of present marriage (living and deceased). Indicate if deceased by putting "D" and give date of death next to name.

Name	Address	Phone #

Client:
Children of a prior marriage:

Name	Address	Phone #

Spouse:
Children of a prior marriage:

Name	Address	Phone #

Please list name and relationships of persons who are dependent on you for support:

_____
_____
_____

GENERAL INFORMATION

	Client Yes/No	Spouse Yes/No
Do you receive Social Security?	_____	_____
If yes, is the check directly deposited?	_____	_____
Have you been appointed as a fiduciary (executor, Trustee, attorney-in-fact, etc.) under any legal Documents?	_____	_____
Are you involved in a lawsuit?	_____	_____
If yes, please explain:		
_____		
_____		
Do any family members require special attention? For example, health, physical, mental, financial status, special and/or individual needs. If yes, please explain:	_____	_____
_____		
_____		
_____		
Do any of your children receive Social Security Disability?	_____	_____
Do any of your children receive Supplemental Security Income (SSI)?	_____	_____
Is anyone at risk of becoming seriously ill or disabled (due to a medical condition or family history)?	_____	_____

HEALTH CARE INFORMATION

	Client Yes/No	Spouse Yes/No
Do you have or receive the following:		
Medicare Part A___ Part B___ Part C___	_____	_____
Supplemental insurance	_____	_____
If yes, name:_____		
Long Term Care insurance	_____	_____
If yes, name:_____		

Medicaid benefits _____ _____

Veterans benefits _____ _____

Served in the Military _____ _____
Dates of Service:_____

DOCUMENTS

	Client Yes/No	Spouse
Please indicate if you have any of the following:		
Will?	_____	_____
If yes, date of Will?_____		
Durable Power of Attorney?	_____	_____
Health Care Power of Attorney?	_____	_____
Living Will?	_____	_____
Trust?	_____	_____
If yes, indicate Irrevocable or Revocable		
_____		
Pre-paid funeral/burial plan?	_____	_____

PROFESSIONAL ADVISORS

Tax Preparer/Accountant:

Name:_____

Company:_____

Address:_____

Telephone: _____

Financial Advisor:

Name:_____

Company:_____

Address:_____

Telephone: _____

INCOME AND EXPENSES

Please list your estimated monthly income and health care expenses.

Monthly Income

Income	Client	Spouse	Total
Social Security	$_____	$_____	$_____
Interest	_____	_____	_____
Dividends	_____	_____	_____
Pension Benefits	_____	_____	_____
IRA Benefits	_____	_____	_____
Rental Income	_____	_____	_____
Other Taxable Income	_____	_____	_____
Other Non-Taxable Income	_____	_____	_____
Total Income:	$_____	$_____	$_____

Monthly Health Care Expenses

	Client	Spouse	Total
Home care	_____	_____	_____
Insurance Premiums	_____	_____	_____
Prescriptions	_____	_____	_____
Nursing Home	_____	_____	_____
Other	_____	_____	_____
Total Expenses:	$_____	$_____	$_____

ASSETS

1. Real Estate

Owner:_____

Location:_____

Estimated Value:_____ **Mortgage Balance:**_____

Owner:_____

Location:_____

Estimated Value:_____ **Mortgage Balance:**_____

Do you receive a senior citizen's exemption on your primary residence? ( ) Yes ( ) No

2. Cash, Bank Accounts and CD's

	Owner	Name of Bank	Amount
Cash			
Checking			
Savings/ Money Market			
CD's			

3. Stocks and Bonds

Owner	Company	Number of Shares	Amount

Brokerage Accounts

Owner	Name of Company	Amount

Savings Bonds

Owner	Type	Number of Bonds	Amount

4. Life Insurance

Owner	Company	Face Amount	Cash Amount	Insured	Beneficiary

5. Retirement Benefits

Pension

Owner	Beneficiary	Principal Amount

401(K) Plan

Owner	Beneficiary	Principal Amount

IRA Accounts

Owner	Beneficiary	Principal Amount

6. Annuities

Owner	Beneficiary	Amount

7. Other Assets

Contracts, Mortgages and Notes (money owed to you)

Owner	Description	Value

Vehicles

Owner	Description	Value

Business Interests (i.e. partnership, corporate interests or sole proprietorships)

Describe:_____
_____
_____

Miscellaneous and Comments:

_____
_____
_____
_____

LIABILITIES

Debts owned by you or your spouse, contractual and leasehold obligations, pending lawsuits and claims, etc.

1. Mortgage

	Name of Debtor	**Amount**
Home Mortgage	_____	
Other Mortgage	_____	

2. General Debts

Credit Cards _____

Notes and accounts payable by you _____
_____

Unsecured Promissory notes _____

Other _____

GIFTS YOU HAVE MADE

Have you or your spouse made any gifts in excess of $11,000 per year per recipient? If yes provide the following information as well as a copy of any filed gift tax returns.

Donor	**Recipient**	**Date Given**	**Amount**