Apperson Crump PLC
6070 Poplar Avenue, 6th Floor
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ELDER CARE FINANCIAL PLANNING QUESTIONNAIRE (MARRIED)

Date____________

This form is extremely important. Your accuracy and completeness in responding will help us best represent you. Please fill in what you can and bring the completed form with you to the appointment.

rev. 4-12

NOTE: PLEASE BRING TO OUR MEETING: COPIES OF RECENT BROKERAGE, BANK, AND ANNUITY STATEMENTS, INFORMATION ABOUT SOCIAL SECURITY AND OTHER INCOME, AS WELL AS POWERS OF ATTORNEYS, WILLS, TRUSTS, AND OTHER PLANNING DOCUMENTS

CLIENT INFORMATION:

(Husband)
Full Name____

(Wife)
Full Name ____________________________________

Street Address____

City____ State___________ Zip__________________

Telephone:_______________________

May we correspond with you by e-mail? Yes ☐ No ☐ If so, state e-mail address: ___________________________

For whom is the planning being done? (Who is the ill spouse?) ____

If ill spouse is no longer at home, where is he/she currently?
Currently living at ____

CLIENT/REPRESENTATIVE:

Note: If senior is unable to act as the client or has asked another to represent him or her in meeting with attorney, please provide the following information.

Client or Representative(s): ____

Relationship to Senior(s): ____

Address(es): ____
____

Contact Telephone Number(s): (H)_____________________ (W)___________________ (C)_____________________

May we correspond with you by e-mail? Yes ☐ No ☐ If so, state e-mail address: ____________________________

A. SENIORS' PERSONAL DATA

HUSBAND	**WIFE**
Age & Birth Date _________ _______________	Age & Birth Date _________ __________________
Social Security No.________________________	Social Security No.______________________
U.S. Citizen? Yes ☐ No ☐	U.S. Citizen? Yes ☐ No ☐
Veteran? Yes ☐ No ☐	Veteran? Yes ☐ No ☐

Existing Documents: **HUSBAND** **WIFE**

1. Do the Spouses have:

	HUSBAND	WIFE
Durable Power of Attorney?	Yes ☐ No ☐	Yes ☐ No ☐
Health Care Power of Attorney?	Yes ☐ No ☐	Yes ☐ No ☐
Living Will?	Yes ☐ No ☐	Yes ☐ No ☐
Valid Will?	Yes ☐ No ☐	Yes ☐ No ☐
Revocable Living Trust?	Yes ☐ No ☐	Yes ☐ No ☐
Special Needs Trust?	Yes ☐ No ☐	Yes ☐ No ☐
Other Planning Documents?	Yes ☐ No ☐	Yes ☐ No ☐

Describe: ____

Is the Ill Spouse competent to execute documents? Yes ☐ No ☐ ____________________

PLEASE BRING COPIES OF EXISTING DOCUMENTS TO OUR FIRST MEETING.

B. MEDICAL DATA

1. HEALTH

(a) Name of Ill Spouse ____________________

Diagnosis ____________________

Prognosis ____________________

Course of Treatment ____________________

Where Ill Spouse Currently Resides ____________________

(b) Name of Well Spouse ____________________

Health of Well Spouse ____________________

Where Well Spouse Currently Resides ____________________

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis. ____________________

2. PHYSICIAN

(a) (Husband)

Full Name of Primary Physician ____________________

Street Address____________________

City____________________ State__________ Zip__________

(b) (Wife)

Full Name of Primary Physician ____________________

Street Address____________________

City____________________ State__________ Zip__________

3. HEALTH INSURANCE

Does the ill spouse have private health insurance or Medicare Supplemental Insurance? Yes ☐ No ☐

Insurance Carrier: ____________________

Cost per month? __________

Long Term Care Insurance? Yes ☐ No ☐ If so, please bring policy to meeting.

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$______________	$______________
Retirement/Pension Benefits (Gross)	$______________	$______________
VA Pension/Disability Benefits	$______________	$______________
Annuity Income	$______________	$______________
Other Income	$______________	$______________
TOTAL MONTHLY INCOME	= $______________	= $______________

Will the pension benefit continue to benefit the retiree's widow? Yes ☐ No ☐

Will the widow's benefit be less than the retiree's? Yes ☐ No☐ If so, what percentage will continue? ______________

D. ASSETS/LIABILITIES Please insert the value of each asset/liability in the appropriate space.

Bring copies of recent bank/investment information to our meeting.

ASSETS (explanation if necessary)		Owned by WIFE Value	Owned by HUSBAND Value	JOINTLY OWNED Value (With Whom?)	**(OFFICE USE ONLY)** COUNTABLE ASSETS
RESIDENCE (ASSESSED VALUE)					
AUTOMOBILE					
CHECKING ACCOUNTS					
SAVINGS ACCOUNTS					
MONEY MARKET ACCOUNTS					
CERTIFICATES OF DEPOSIT					
IRA'S					
MUTUAL FUNDS					
STOCKS & BONDS					
ANNUITIES					
OTHER REAL ESTATE					
CASH VALUE - LIFE INSURANCE (Total from Sch. H)					
PREPAID FUNERAL AND BURIAL PLOTS					
OTHER					
TOTALS					

E. MONTHLY EXPENSES (Excluding Home)
(Home/household expenses on next page)

$________________ Monthly Nursing Home/Assisted Living Cost

$________________ Monthly Prescription Cost

$________________ Monthly Supplies/Incontinent Cost

$________________ Health Insurance Premiums

$________________ Caregiver Costs

$________________ Other ____________________________

____

= $________________ **Total Monthly Non-Shelter Living Expenses**

The facility is paid up through ____ (month/year).

F. HOME/SHELTER EXPENSES

$________________/month Rent/Mortgage

$________________ Annual Real Estate Taxes (City and County)

$________________/month MLG&W Utilities (Water, Sewer, Heat, Electric & Telephone) (monthly average of 12 months)

$________________/______ Homeowner's (House) insurance premium (indicate annual or monthly)

$ _______________/month Household upkeep and maintenance expenses

$________________/month Condominium/Association fees

$________________ **Total Average Monthly Housing Expenses**

G. GIFTS

Please list gifts made in excess of $1,000 to an individual or group of individuals within the past 5 years:

Recipient________________________________ Date _______________ Amount ___________

Recipient________________________________ Date _______________ Amount ___________

Recipient________________________________ Date _______________ Amount ___________

Recipient________________________________ Date _______________ Amount ___________

Have you ever filed a Federal Gift Tax Return? Yes ☐ No ☐
If so, please state details____

H. LIFE INSURANCE **If any insurance is from a Term or Group Policy, check Term in box. If it is Burial Insurance, check in box.**

Insurance Company	Indicate Type	Values*	Who is the:	Owner
	Term ☐	Face:	Insured:	
		Cash:	Benefic.:	
	Term ☐	Face:	Insured:	
		Cash:	Benefic.:	
	Term ☐	Face:	Insured:	
	Burial ☐	Cash:	Benefic.:	
	Term ☐	Face:	Insured:	
	Burial ☐	Cash:	Benefic.:	

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, check the annual statement from the company or call the insurance company directly.

***Include the Total Cash Value of the life insurance in the Life Insurance line in Section H.**

I. CHILDREN (if applicable)

1. ______________________________ Telephone: ____________
Name
______________________________ Age: ________ Disabled? ☐
Street Address
______________________________ Married? ☐ Divorced? ☐
City, State, Zip
Any Children? If so, how many? ______

2. ______________________________ Telephone: ____________
Name
______________________________ Age: ________ Disabled? ☐
Street Address
______________________________ Married? ☐ Divorced? ☐
City, State, Zip
Any Children? If so, how many? ______

3. ______________________________ Telephone: ____________
Name
______________________________ Age: ________ Disabled? ☐
Street Address
______________________________ Married? ☐ Divorced? ☐
City, State, Zip
Any Children? If so, how many? ______

4. ____ Telephone: ____________________

Name

____ Age: ________ Disabled? ☐

Street Address

____ Married? ☐ Divorced? ☐

City, State, Zip

Any Children? If so, how many? ______

(Attach additional page if needed)

Are any of the children or grandchildren blind or disabled? Yes ☐ No ☐

Have all of the children completed their education? Yes ☐ No ☐

Are any of the children receiving SSI or other form of Government entitlement payments? Yes ☐ No ☐

Do any of the family members have any financial or health problems? Yes ☐ No ☐
If so, please explain in conference.

Do any of the children or siblings live with you in Senior's home? Yes ☐ No ☐

If yes, name of child or sibling: ________________________________ For how long? ____________________

J. MISCELLANEOUS

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

If yes, please explain ____

____

K. REFERRAL

How did you find out about us? ____

L. CERTIFICATION

The undersigned hereby affirms the information herein is accurate to the best of undersigned's knowledge. 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:

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