Apperson Crump PLC
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ELDER CARE LEGAL PLANNING QUESTIONNAIRE (UNMARRIED)

Date _____

rev 4-12

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.

A. SENIOR'S PERSONAL DATA

Full Name _____

Home Address_____

City_____ State_____ Zip_____

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

Where is Senior currently residing (if different)? _____

Telephone: _____

Age & Birth Date _____ _____

Social Security No._____

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐ If Spouse is deceased, was Spouse a veteran? Yes ☐ No ☐

Existing Planning Documents:

1. Does Senior have a Durable Power of Attorney? Yes ☐ No ☐ Health Care Power of Attorney? Yes ☐ No ☐

2. Does Senior have a Will, Living Trust or similar document? Yes ☐ No ☐

Is the Elder still able to execute legal documents? Yes ☐ No ☐ _____

PLEASE BRING COPIES OF EXISTING DOCUMENTS TO OUR FIRST MEETING.

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: _____

Address: _____

_____

_____

Contact Telephone Number(s): _____ _____

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

B. MEDICAL DATA

1. HEALTH

General Health of Senior _____

Diagnosis _____

Prognosis _____

Course of Treatment _____

If Senior has entered a nursing home, please state the name of the nursing home and the date first entered on a continuous basis: _____ Date: _____

2. PHYSICIAN

Name of Primary Physician _____

Street Address_____

City_____ State_____ Zip_____

3. HEALTH INSURANCE

Does Senior have private health insurance or Medicare Supplemental Insurance? Yes ☐ No ☐
Insurance Carrier: _____
Cost per month? _____

Long Term Care Insurance? Yes ☐ No ☐ Bring long term care policy with you, if you have one.

C. APPROXIMATE MONTHLY COST OF CARE—At Home/Nursing Home/Assisted Living

$_____ Monthly Nursing Home/Assisted Living Cost

$_____ Monthly Prescription Cost

$_____ Monthly Supplies, Misc. Expenses

$_____ Monthly Home Mortgage, Taxes, Insurance

$_____ Other Costs _____

Total: $_____ **Total Monthly Costs**

The nursing home is paid up through _____ (month/year).

D. MONTHLY INCOME

	Monthly Income	
Social Security Benefits	$_____	Is this after Part B deduction? _____
Retirement/Pension Benefits (Gross)	$_____	
VA Pension/Disability Benefit	$_____	Aid & Attendance? Yes ☐ No ☐ Unsure ☐
Annuity Income	$_____	
Rental, Interest and Other Income	$_____	
TOTAL MONTHLY INCOME	$_____	

If there is a pension, if possible, please list the *gross pension amount* (do not deduct any monies taken out for federal income taxes, health insurance, or any other reason).

E. 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)		SOLE OWNERSHIP PROPERTY	JOINTLY OWNED PROPERTY (With Whom? Indicate Below.)	Debt	**(For Office Use Only)** COUNTABLE VALUE
RESIDENCE (Current ASSESSED VALUE)					
AUTOMOBILE (second auto countable)					
CHECKING ACCOUNT					
SAVINGS ACCOUNT					
MONEY MARKET ACCOUNT					
CERTIFICATES OF DEPOSIT					
IRA'S					
MUTUAL FUNDS					
STOCKS & BONDS					
ANNUITIES					
OTHER REAL ESTATE					
CASH VALUE - LIFE INSURANCE (Total from Schedule G)					
PREPAID FUNERAL/BURIAL PLOT					
OTHER					
TOTALS					

Does Senior own any real estate other than personal residence?

(1) Type: _____

Location: _____

Current Value: _____

What did you pay for this property including any improvements? _____
(Attach additional information if necessary)

F. 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_____

G. 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.

*Also show the total **Cash Value** of all of the life insurance in the Life Insurance line in Section E.

H. **CHILDREN** and other family members (If applicable, use back to continue, if necessary.)

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

. _____ 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? If so, please explain in conference. Yes ☐ No ☐

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? _____

I. MISCELLANEOUS

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

If yes, please explain _____

_____

_____

J. REFERRAL

How did you find out about us? _____

K. CERTIFICATION

The undersigned hereby represents that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers 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:

_____