

**ELDER CARE LEGAL PLANNING QUESTIONNAIRE
(UNMARRIED)**

Date _____

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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 <input type="checkbox"/>	Face:	Insured:	
		Cash:	Benefic.:	
	Term <input type="checkbox"/>	Face:	Insured:	
		Cash:	Benefic.:	
	Term <input type="checkbox"/> Burial <input type="checkbox"/>	Face:	Insured:	
		Cash:	Benefic.:	
	Term <input type="checkbox"/> Burial <input type="checkbox"/>	Face:	Insured:	
		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? _____

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? _____

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:
