

**ELDER CARE FINANCIAL PLANNING QUESTIONNAIRE
(MARRIED)**

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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. 2-21

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:

- | | | |
|--------------------------------|--|--|
| Durable Power of Attorney? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Health Care Power of Attorney? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Living Will? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Valid Will? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Revocable Living Trust? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Special Needs Trust? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Other Planning Documents? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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		(OFFICE USE ONLY) COUNTABLE ASSETS
				Value	(With Whom?)	
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 <input type="checkbox"/>	Face:	Insured:	
		Cash:	Benefic.:	
	Term <input type="checkbox"/>	Face:	Insured:	
		Cash:	Benefic.:	
	Term <input type="checkbox"/>	Face:	Insured:	
	Burial <input type="checkbox"/>	Cash:	Benefic.:	
	Term <input type="checkbox"/>	Face:	Insured:	
	Burial <input type="checkbox"/>	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 D.**

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. _____
Name

Street Address

City, State, Zip

Telephone: _____

Age: _____ Disabled?

Married? Divorced?

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:
