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A PROFESSIONAL CORPORATION

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CONFIDENTIAL

LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend, **the "Client"**) during a time when there may be a need for Long-Term Care. We have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

DATE: _____

SECTION 1. NAME AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

_____

Relationship to Client: _____

Client's Power of Attorney for Property: _____

Client's Full Name: _____
(first) (middle) (last)

Home Address: _____

_____

Client

Telephone Numbers: _____
(home)

_____
(cell)

Date of Birth: _____

Former/Maiden Names: _____

US Citizen?: ◯ Yes ◯ No

Military Service: _____

SECTION 2. CLIENT'S FAMILY INFORMATION

A. Client's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ ◯ Death ◯ Divorce
(year terminated) (how terminated)

◯ Yes ◯ No _____
(still living?) (if still living, describe relationship)

2. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ ◯ Death ◯ Divorce
(year terminated) (how terminated)

◯ Yes ◯ No _____
(still living?) (if still living, describe relationship)

B. Client's Children

List all children. Copy and attach additional pages, if needed. Total number of children: _____

1. _____ _____ _____
(name of child) (date of birth) (social security number)

_____ _____
(current address) (phone number)

☐ Adopted _____ _____
(date of adoption) (court granting adoption)

☐ Deceased _____ ◯ Yes ◯ No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

2. _____ _____ _____
(name of child) (date of birth) (social security number)

_____ _____
(current address) (phone number)

☐ Adopted _____ _____
(date of adoption) (court granting adoption)

☐ Deceased _____ ◯ Yes ◯ No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

3. _____ _____ _____
(name of child) (date of birth) (social security number)

_____ _____
(current address) (phone number)

☐ Adopted _____ _____
(date of adoption) (court granting adoption)

☐ Deceased _____ ◯ Yes ◯ No _____
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

4. _____ _____ _____
(name of child) (date of birth) (social security number)

_____ _____
(current address) (phone number)

☐ Adopted _____ _____
(date of adoption) (court granting adoption)

☐ Deceased _____ ◯ Yes ◯ No _____
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

5. _____ _____ _____
(name of child) (date of birth) (social security number)

_____ _____
(current address) (phone number)

☐ Adopted _____ _____
(date of adoption) (court granting adoption)

☐ Deceased _____ ◯ Yes ◯ No _____
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

SECTION 3. DISPOSITIVE PLANNING

In general, to whom and how does the Client want property distributed upon death? Consider family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations.

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

A. First-choice beneficiaries: ◯ Children ◯ Other

B. Second-choice beneficiaries: ◯ Children ◯ Other

C. Any specific disposition of Client's residence?

D. Any specific gifts of Client's special articles, such as art or jewelry?

E. Any specific disposition of Client's household and personal effects?

F. Other information you think is important to Client's estate planning:

SECTION 4. FIDUCIARIES

Please consider the who you want to handle your affairs when you cannot.

A. FIDUCIARIES: EXECUTOR & TRUSTEE (Co-Fiduciaries Act: ☐ Separately ☐ Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)

◯ Co-Fiduciary with #1 (May surviving Co-Fiduciary act alone? ◯ Yes ◯ No)
or ◯ Successor Fiduciary

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)

◯ Co-Fiduciary with #2 (May surviving Co-Fiduciary act alone? ◯ Yes ◯ No)
or ◯ Successor Fiduciary

_____
(current address) (phone number)

4. _____ _____
(name) (relationship)

◯ Co-Executor with #3 (May surviving Co-Fiduciary act alone? ◯ Yes ◯ No)
or ◯ Successor Fiduciary

_____
(current address) (phone number)

B. AGENTS UNDER PROPERTY POWER OF ATTORNEY (Co-Agents are not allowed)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

☐ There is already a power of attorney in place naming this person

2. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

☐ There is already a power of attorney in place naming this person

3. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

☐ There is already a power of attorney in place naming this person

4. _____ _____
(name) (relationship)

_____ _____
(current address)

☐ There is already a power of attorney in place naming this person

C. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY (Co-Agents are not allowed)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

☐ There is already a power of attorney in place naming this person

2. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

☐ There is already a power of attorney in place naming this person

3. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

☐ There is already a power of attorney in place naming this person

4. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

☐ There is already a power of attorney in place naming this person

SECTION 5. CLIENT'S HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems, and whether there has been an official diagnosis.

_____

_____

_____

SECTION 6. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: ◯ Yes ◯ No

If yes, please explain:

_____

_____

_____

B. OTHER ISSUES

	Client
Able to sign name?:	◯ Yes ◯ No
Able to speak?:	◯ Yes ◯ No
Able to recognize friends and family?:	◯ Yes ◯ No
Cognizant of property and possessions?:	◯ Yes ◯ No
Able to leave current residence?:	◯ Yes ◯ No

SECTION 7. CLIENT'S PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of Client's primary physician.

Physician's Name: _____

Specialty: _____

Address: _____

_____

Business Phone: _____

SECTION 8. RESIDENCE -- (IF CLIENT OWNS THEIR RESIDENCE; OTHERWISE SKIP TO SECTION 9)

A. Owners: _____

B. How is title held? _____

PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL

C. Fair Market Value: $ _____

D. Mortgage Balance: $ _____

Is it a Reverse Mortgage? ◯ Yes ◯ No

Basic Mortgage Terms: _____

E. Single Family Residence? ◯ Yes ◯ No

F. If the property is rental property, please provide the following:

1. Number of units: _____
2. Currently being rented? ◯ Yes ◯ No
3. Are tenants under lease? ◯ Yes ◯ No

G. If the property was purchased, please provide the following:

1. Date of Purchase: _____
2. Purchase Price: $ _____

H. If the property was inherited, please provide the following:

1. Month/Year Inherited: _____
2. Value when Inherited: $ _____

I. If improvements have been made to the property, please detail the value and nature of them:

_____

_____

_____

J. Have the owners used the capital gains tax exclusion? ☐ Yes ☐ No

K. If at least one occupant of the residence is a child of the individual in need of long-term care, has that child lived in the residence for at least 2 years? ◯ Yes ◯ No

1. If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? ◯ Yes ◯ No

2. If so, please describe the nature and duration of the care provided:

_____

_____

_____

L. Does the person needing care have any living children who are disabled? ◯ Yes ◯ No

SECTION 9. RESIDENCE -- (IF CLIENT RENTS THEIR RESIDENCE)

A. Monthly Rent: $ _____

B. Type of Rental: ◯ Single Family ◯ Apartment ◯ Residential Care ◯ Life Care ◯ Senior Housing

C. Rental/Lease Agreement? ◯ Yes ◯ No

D. Is Rent Subsidized? ◯ Yes ◯ No

If so, by whom and amount? _____

SECTION 10. LONG-TERM CARE (LTC)

A. Client

Currently Receiving LTC? ◯ Yes ◯ No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

SECTION 11. HOSPITAL

A. Client

Currently in Hospital? ◯ Yes ◯ No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? ◯ Yes ◯ No

If so, likely to return home? ◯ Yes ◯ No

SECTION 12. DEBT

Enter the outstanding balance of debt.

Description/Type of Debt	Whose debt?	Creditor	Balance
Credit card (sample)	*John and Jane's*	*US Bank*	*$ xx,xxx.xx*
			$
			$
			$
			$
			$
			$

SECTION 13. INCOME

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment vehicle is the "owner" of the income.

A. FIXED MONTHLY INCOME

		Client		
1.	Social Security:	$	$	$
2.	Retirement:	$	$	$
3.	Pension:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$
6.	_____:	$	$	$

B. NON-FIXED MONTHLY INCOME

		Client		
1.	Interest:	$	$	$
2.	Dividends:	$	$	$
3.	_____:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$

C.	**TOTALS (A thru B):**	**$**	**$**	**$**

SECTION 14. ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.) (Please provide copies of statements)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. (sample)	*xxx-xxxx*	*Savings*	*$ xx,xxx.xx*	*Jointly w/ son*
			$	
			$	
			$	
			$	

B. SECURITIES (Bonds, Marketable Securities, etc.) (Please provide copies of statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. (sample)	*Common* (or Preferred)	*xx Shares*	*$ x,xxx.xx*	*$ x,xxx.xx*	*Sole owner*
			$	$	
			$	$	
			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.) (Please provide copies of statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker (sample)	*xxx-xxxx*	*Client*	*Spouse*	*Jan, 1970*	*$ xx,xxx.xx*
					$
					$
					$
					$
					$

D. REAL ESTATE
(Please provide copies of deeds and most recent tax bills)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
123 Know Way (sample)	*$ xxx,xxx.xx*	*$ xxx,xxx.xx*	*$ xx,xxx.xx*	*Joint tenant*
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	

E. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$	
Cars, RVs, Boats, etc.:	$	
Jewels, Furs, etc.:	$	
_____: (other: collectibles, etc.)	$	
_____:	$	
_____:	$	

F. BUSINESS INTERESTS

If the Client has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which the Client has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

H. MISCELLANEOUS

If the Client has any property interests not described above, please explain the nature of the interests and the estimated value of each (but not life insurance—see Section 19).

Is the client expecting any large sum/windfall such as inheritance or a lawsuit settlement?

SECTION 15. EXEMPT RESOURCES

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

	Client
Burial plot:	◯ Yes ◯ No
Irrevocable burial fund contract:	◯ Yes ◯ No

SECTION 16. PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the Client? Please list name, phone number, and relationship to the person receiving the care.

A. Responsible for Client:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

3. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

SECTION 17. UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

_____

_____

_____

SECTION 18. MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*: $ _____

2. If home is rented, total rent, including maint. fees, if any: $ _____

* Is the senior citizen real property tax exemption being used? ☐ Yes ☐ No
Is the veterans real property tax exemption being used? ☐ Yes ☐ No

B. INSURANCE PREMIUMS (PER MONTH)

Client

1. Health insurance: $ _____

2. Long-term care insurance: $ _____

3. _____: $ _____
(specify)

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

Client

1. Non-covered medications: $ _____

2. _____: $ _____
(specify)

3. _____: $ _____
(specify)

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

Client

1. Food: $ _____

2. Entertainment and travel: $ _____

3. Support for children: $ _____

4. _____: $ _____
(specify)

5. _____: $ _____
(specify)

E. TOTALS (A thru D): $ _____

SECTION 19. HEALTH AND LTC INSURANCE

If the Client has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
Acme Insurance	*123-45-6789*	*Long-term care*	*$ 3,000*	*$ 300.00 per day*
(sample)				
			$	$
			$	$
			$	$

SECTION 20. LIFE INSURANCE

If the person needing care has life insurance, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	Cash Surrender Value
Acme Insurance	*123-45-6789*	*Whole Life*	*$ 1,000*	*$ 10,000*
(sample)				
			$	$
			$	$
			$	$

SECTION 21. PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

Will: ☐ Yes ☐ No

Revocable Living Trust: ☐ Yes ☐ No

Pour-Over Will: ☐ Yes ☐ No

General Durable Power of Attorney: ☐ Yes ☐ No

Health Care Power of Attorney (or Proxy): ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No

_____: ☐ Yes ☐ No

_____: ☐ Yes ☐ No

_____: ☐ Yes ☐ No

(specify)

SECTION 22. TRANSFERS WITHIN 60 MONTHS

Has the person needing care gratuitously transferred property to someone within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**: Please include transfers for financial assistance to anyone, other than in exchange for work.

	Recipient	Amount/Value of Gift	Date of Gift
1.		$	
2.		$	
3.		$	
4.		$	

SECTION 23. TRANSFERS TO OR FROM TRUSTS

Has the Client transferred property into a Trust—like an Irrevocable Life Insurance Trust (ILIT)—or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

SECTION 24. CLIENT'S GOALS

What are your goals?

_____

_____

_____

_____

_____

_____

_____

_____

_____