

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

File # _____ 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.

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rev 1-10

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

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. You may add schedules if necessary for multiple accounts and CD's.

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 in any one year, to an individual or group of individuals, within the past 5 years. (attach list, if necessary):

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 [] Burial []	Face:	Insured:	
		Cash:	Benefic.:	
	Term [] Burial []	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: _____
Street Address
_____ Married? ____ Divorced? ____
City, State, Zip
Children? ____ _____

2. _____ Telephone: _____
Name
_____ Age: _____
Street Address
_____ Married? ____ Divorced? ____
City, State, Zip
Children? ____ _____

3. _____ Telephone: _____
Name
_____ Age: _____
Street Address
_____ Married? ____ Divorced? ____
City, State, Zip
Children? ____ _____

4. _____ Telephone: _____
Name
_____ Age: _____
Street Address
_____ Married? ____ Divorced? ____
City, State, Zip
Children? ____ _____

Are any of the children 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

By whom were you referred to this office? May we contact them to thank them? _____

Name _____

Street Address _____

City _____ State _____ Zip _____

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:
