

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

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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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) _____ **(Wife)** _____
Full Name _____ 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): _____

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 No Yes No
- Health Care Power of Attorney?** Yes No Yes No
- Living Will?** Yes No Yes No
- Valid Will?** Yes No Yes No
- Revocable Living Trust?** Yes No Yes No
- Other Planning Documents?** Yes No Yes No

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? _____

Medicare Part B? Yes No 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? _____

H. ASSETS/LIABILITIES Please insert the **value** of each asset/liability in the appropriate space.

Use back side for multiple accounts and CD's. If assets are jointly held with another (child, etc., indicate below).

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						

(Attach additional information if necessary)

**D. 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 _____
<hr/>	
= \$ _____	Total Monthly Non-Shelter Living Expenses

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

E. 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 <u>Monthly</u> Housing Expenses

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:

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:	
		Cash:	Benefic.:	
	Burial? []			

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 H.**

I. CHILDREN (if applicable)

1. _____ Telephone: _____
 Name _____ Age: _____
 Street Address _____ Married? ____ Divorced? ____
 City, State, Zip _____ Any Children? If so, how many? _____
2. _____ Telephone: _____
 Name _____ Age: _____
 Street Address _____ Married? ____ Divorced? ____
 City, State, Zip _____ Any Children? If so, how many? _____
3. _____ Telephone: _____
 Name _____ Age: _____
 Street Address _____ Married? ____ Divorced? ____
 City, State, Zip _____ Any Children? If so, how many? _____
4. _____ Telephone: _____
 Name _____ Age: _____
 Street Address _____ Married? ____ Divorced? ____
 City, State, Zip _____ Any Children? If so, how many? _____

(Attach page if additional room is needed)

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? _____

J. MISCELLANEOUS

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

If yes, please explain _____

K. REFERRAL

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

Name _____

Street Address _____

City _____ State _____ Zip _____

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:
