



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) during a time when there may be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and ask you to complete it prior to your consultation. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

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DATED: \_\_\_\_\_

**I. CLIENT & FAMILY**

**Client Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ US Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Tel No.: Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Annual Income: \_\_\_\_\_

**Spouse/Partner Name:** \_\_\_\_\_

Date of Marriage or Domestic Partnership: \_\_\_\_\_ State: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_ US Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Tel No.: Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Annual Income: \_\_\_\_\_

**Client (Prior Marriages)**

Name of Former Spouse: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

Place of Marriage: \_\_\_\_\_ Year Terminated: \_\_\_\_\_

**Spouse (Prior Marriages)**

Name of Former Spouse: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

Place of Marriage: \_\_\_\_\_ Year Terminated: \_\_\_\_\_

**CHILDREN, GRANDCHILDREN AND/OR RELATIVES**

**1. Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ US Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Tel No.: Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**2. Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ US Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Tel No.: Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**3. Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ US Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Tel No.: Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**4. Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ US Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Tel No.: Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**5. Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ US Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_

Tel No.: Home: \_\_\_\_\_ Wk: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**II. BUSINESS INTERESTS:**

**Name:** \_\_\_\_\_ **Value:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Tel No.: Office \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Succession Planning: [ ] Public, or Private Sale [ ] Buy & Sell Agreement [ ] Family

Continuation

[ ] Insurance [ ] Gifts & Transfers [ ] Key Man [ ] Consulting Agreement [ ] Independent

Board of Directors [ ] Other \_\_\_\_\_

**III. HEALTH RELATED PROBLEMS**

Health Problems: Client

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health Problems: Spouse/Significant Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. CAPACITY**

Are there any known problems with the individual’s memory or understanding?

Client: Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse/Significant

Other: Yes \_\_\_\_\_ No \_\_\_\_\_

If you answered yes, please describe the nature of the problem:

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Please indicate Yes or No to the following questions:

	<u>Client</u>	<u>Spouse/Significant Other</u>
Is the individual able to sign his or her name?	_____	_____
Able to speak?	_____	_____
Able to recognize family members and acquaintances?	_____	_____
Cognizant of his or her property and personal possessions?	_____	_____
Able to travel outside his or her current place of residence?	_____	_____

**V. PHYSICIAN’S INFORMATION**

*(Please list the name and address of your primary physician)*

	<u>Client</u>	<u>Spouse/Significant Other</u>
Physician’s Name:	_____	_____
Specialty:	_____	_____
Address:	_____	_____
	_____	_____
Business Telephone:	_____	_____

**VI. RESIDENCE – OWNED**

A. Owner(s): \_\_\_\_\_

B. How is the title held? \_\_\_\_\_

**PLEASE PROVIDE US WITH A COPY OF THE DEED AND MOST RECENT TAX BILL.**

C. Fair Market Value? \$ \_\_\_\_\_

Outstanding Mortgage

D. (list amount): \$ \_\_\_\_\_

If so, is it a Reverse Annuity Mortgage (RAM)? Yes \_\_\_\_\_ No \_\_\_\_\_

Basic terms: \_\_\_\_\_

E. Single family residence? Yes \_\_\_\_\_ No \_\_\_\_\_

F. If the property was purchased, 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 of inheritance \_\_\_\_\_

2. Value on date of inheritance:  
(if available) \$ \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

J. Has (have) the owner(s) used the principal residence capital gains tax exclusion? Yes \_\_\_\_\_ No \_\_\_\_\_

K. If at least one occupant of the residence is a child of the individual needing long-term care, has that child lived in the residence for at least two (2) years? Yes \_\_\_\_\_ No \_\_\_\_\_

1. Has the child provided personal care to the parent(s) that might have delayed the need for long-term care for the parent(s)? Yes \_\_\_\_\_ No \_\_\_\_\_

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

\_\_\_\_\_

L. Do the individual(s) needing care have any living children who are disabled? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe the nature of the disability:

\_\_\_\_\_

M. If the owner has a brother or sister, has the brother or sister lived in the house for at least one (1) year? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, does the sibling still reside in the home? Yes \_\_\_\_\_ No \_\_\_\_\_

**VII. RESIDENCE – RENTED**

Monthly Cost: \$ \_\_\_\_\_

Type of rental: Single Family \_\_\_\_\_ Apartment \_\_\_\_\_  
Residential Care \_\_\_\_\_ Life Care \_\_\_\_\_  
Senior Housing \_\_\_\_\_

Is there a rental or lease agreement? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the rent being subsidized? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, by whom and for how much? \_\_\_\_\_ \$ \_\_\_\_\_

**VIII. LONG-TERM CARE (LTC)**

Is the individual(s) currently receiving long-term care? (*please indicate yes or no*) Client \_\_\_\_\_ Spouse/Significant Other \_\_\_\_\_

If so, what was the date of entry into the nursing home or facility, or the date the home care was started? \_\_\_\_\_

Name of the LTC facility/provider: \_\_\_\_\_

Address: \_\_\_\_\_

Business Telephone: \_\_\_\_\_

Administrator or other contact: \_\_\_\_\_

**IX. HOSPITAL**

Client
Spouse/Significant Other

Is either individual currently in a hospital?  
*Please indicate yes or no.*

Name/Location of the Hospital: \_\_\_\_\_

Date admitted: \_\_\_\_\_

Please list the current duration of the hospital stay, and a brief description of the medical problem:

\_\_\_\_\_

Client
Spouse/Significant Other

Is placement in a LTC facility expected?  
*Please indicate yes or no.*

If placement is expected, is it likely that he or she will return home?

\_\_\_\_\_

\_\_\_\_\_

**X. INCOME**

*In completing the following section, use the “name on the check” rule, i.e., the individual(s) whose name appears on the payment vehicle is the “owner” of the income.*

<u>Fixed Monthly</u>	<u>Client</u>	<u>Spouse/Significant Other</u>	<u>Joint</u>
Social Security	\$ _____	\$ _____	\$ _____
R.R. Retirement	\$ _____	\$ _____	\$ _____
Pension	\$ _____	\$ _____	\$ _____
Other (describe)			
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
<b>Non-Fixed Monthly</b>			
Interest	\$ _____	\$ _____	\$ _____
Dividends	\$ _____	\$ _____	\$ _____
Other (describe)			
_____	\$ _____	\$ _____	\$ _____
_____	\$ _____	\$ _____	\$ _____
<b>TOTAL INCOME</b>	<b>\$ _____</b>	<b>\$ _____</b>	<b>\$ _____</b>

**XI. ASSETS/RESOURCES**

**Cash, CDs and Bank Balances:**

<u>Name of Bank/Branch</u>	<u>Account No.</u>	<u>Type of Account</u>	<u>Balance/ Current Value</u>	<u>How Title Held</u>

**Securities (Bonds, Marketable Securities, etc.): (Or attach stock brokerage account statement)**

<u>Company/Insurer</u>	<u>Type (Common/ Preferred)</u>	<u>No. of Shares/ Face Value</u>	<u>Cost</u>	<u>Current Value</u>	<u>How Title Held</u>

**Life Insurance:**

<u>Company/Policy #</u>	<u>Name of Insured</u>	<u>Face Value</u>	<u>Current Cash Surrender Value</u>	<u>Owner of Policy</u>	<u>Named Beneficiary(s)</u>

**IRA, Keogh, and/or Other Retirement Plans (provide copies of plan documents and beneficiary designations):**

<u>Institution Where Held/Acct. No.</u>	<u>Owner</u>	<u>Beneficiary</u>	<u>Date Established</u>	<u>Current Value</u>
#				\$
#				\$
#				\$
#				\$

**Real Estate: Please provide us with a copy of the deed and most recent tax bill.**

<u>Description</u> (Location)	<u>Title Held</u>	<u>Cost/Basis</u>	<u>Outstanding</u> <u>Mortgages</u>	<u>Market Value</u>
1.				
2.				
3.				

**Personal Property: (Indicate how ownership is held)**

	<u>Value</u>	<u>How Held</u>
Home Furnishings:	\$	
Automobiles, Boats, etc.	\$	
Jewels &/or furs:	\$	
Other (collections, etc.)	\$	

**Rights or Interests in Trusts, Estates, or Prospective Inheritance:**

Briefly describe or give the name of the Trust in which the individual(s) needing long-term care 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.

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**Miscellaneous:**

If either (or both) individual(s) needing long-term care has any property interests not described above, please explain the nature of the interest and the estimated value thereof:

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**XII. 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 individual needing care has the listed items: (please indicate yes or no)

	<u>Client</u>	<u>Spouse/Significant Other</u>
Burial plot: (Please provide a copy of deed)	_____	_____
Irrevocable burial fund contract: (Please provide a copy)	_____	_____

**XIII. RESPONSIBLE PERSONS**

Who now has “assistance” responsibilities (i.e., are any family member or other individuals providing custodial or other types of care to the individual needing assistance)? Please list name, phone number, and relationship to the person receiving the care:

For Client:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

For Spouse/Significant Other:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**XIV. UNAVAILABLE CHILD(REN)**

If the individual needing care has children, and any child(ren) are not to be relied upon for any reason to help with management or other needs of parent(s), please list name of such child(ren) and provide a short explanation why you believe such is the case:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**XV. COST OF LIVING (ESTIMATED PER MONTH)**

<u>Housing</u>	<u>Client</u>	<u>Spouse/Partner</u>	<u>Joint</u>
If home is owned, estimate total cost of mortgage, taxes, utilities, phone, etc.* (Monthly)	\$ _____	\$ _____	\$ _____
If rented, estimate monthly rental/lease expense (including any maintenance fees)	\$ _____	\$ _____	\$ _____

Insurance Premiums  
(Monthly)

Health	\$	\$	\$
Long-term care	\$	\$	\$
Other (specify): <u>Medical Expenses</u>	\$	\$	\$
Non-covered medications (monthly est.)	\$	\$	\$
Other (specify):	\$	\$	\$
	\$	\$	\$
<u>Basic Living Expenses</u>			
Food	\$	\$	\$
Entertainment & Travel	\$	\$	\$
Support for child(ren)	\$	\$	\$
Other (specify):	\$	\$	\$
TOTALS	\$	\$	\$

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

**XVI. HEALTH AND LTC INSURANCE**

*Use back of form if necessary (Please provide us with a copy of each document)*

If either and/or both individual(s) have Medicare Parts A, B and/or D, private health or long-term care insurance, or are paying for a Medicare supplement policy, please provide the following information:

<u>Name of Insurer and Policy #</u>	<u>Type of Policy</u>	<u>Monthly Premium</u>	<u>If LTC Insurance Daily Benefit</u>
#		\$	\$
#		\$	\$
#		\$	\$

**XVII. TRANSFERS WITHIN 60 MONTHS**

Has the individual(s) transferred property to someone other than his or her spouse within the past sixty (60) months? If so, please provide the following information:

Client:

<u>Recipient</u>	<u>Amount</u>	<u>Date</u>
	\$	
	\$	

Gift tax returns filed on any gifts? (Please provide copies, if available)  Yes  No

Spouse/Significant Other:

<u>Recipient</u>	<u>Amount</u>	<u>Date</u>
	\$	
	\$	
	\$	

Gift tax returns filed on any gifts? (Please provide copies, if available)  Yes  No

**XVIII. TRANSFERS TO OR FROM TRUSTS**

Has the individual(s) transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past sixty (60) months?

Client: Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse/Significant Other: Yes \_\_\_\_\_ No \_\_\_\_\_

If so, please provide the following information:

<u>Name of Trust</u>	<u>Amount</u>	<u>Date</u>
	\$	
	\$	



**XX. HEALTH CARE PROXY:** (To make medical decisions on your behalf if you are unable.)

Name:	Address:	Phone:
(1) _____,	_____	_____
(2) _____,	_____	_____
(3) _____,	_____	_____

**XXI. DURABLE POWER OF ATTORNEY:** (To make financial decisions if you are unable.)  
Note: A Separate Power of Attorney can be made for Business matters.

Springing       General Durable

Name:	Address:	Phone:
(1) _____,	_____	_____
(2) _____,	_____	_____
(3) _____,	_____	_____

Agents to act:       TOGETHER    or     SEPARATELY?

Agent(s) to be given Gifting Authority:     Yes       No

**Successor Agent(s):** (If your Primary Agent(s) above is unable or refuse to serve)

Successor Agent Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

**XXII. DISPOSITION OF REMAINS APPOINTMENT:** (Designated to handle one's remains and final arrangements once deceased.)

Name:	Address:	Phone:
(1) _____,	_____	_____
(2) _____,	_____	_____
(3) _____,	_____	_____

**Funeral Instructions:** (If any – Check Applicable)

- Cremation    Memorial Service    Calling Hours    Open casket    Closed casket
- Service at Funeral Home    Service/Mass in Church    With casket    Interment service at Cemetery
- Other: \_\_\_\_\_

**Funeral Home:** \_\_\_\_\_   **Pre-Planned:**  Yes    No

**Cemetery Plot:** \_\_\_\_\_

**Please see the following page for a complete checklist**

## CHECKLIST OF ITEMS

**Check if you have any of the following instruments, and provide copies if available.**

Client	Spouse/Significant Other	
<input type="checkbox"/>	<input type="checkbox"/>	Prior Will
<input type="checkbox"/>	<input type="checkbox"/>	Any existing Trust documents where listed as donor or beneficiary
<input type="checkbox"/>	<input type="checkbox"/>	Power of Attorney
<input type="checkbox"/>	<input type="checkbox"/>	Living Will and/or Health Care Proxy
<input type="checkbox"/>	<input type="checkbox"/>	Business Agreements (Partnership/Shareholder)
<input type="checkbox"/>	<input type="checkbox"/>	Pre-Nuptial Agreement
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Right of Election
<input type="checkbox"/>	<input type="checkbox"/>	Deeds to Real Property
<input type="checkbox"/>	<input type="checkbox"/>	Recent Tax Bill Associated with Deeds
<input type="checkbox"/>	<input type="checkbox"/>	Real Property Appraisals
<input type="checkbox"/>	<input type="checkbox"/>	Qualified Plan/IRA/ 401(k) Documents
<input type="checkbox"/>	<input type="checkbox"/>	Bank Account / CD Statements
<input type="checkbox"/>	<input type="checkbox"/>	Investment Statements (Stocks, Bonds, Mutual Funds)
<input type="checkbox"/>	<input type="checkbox"/>	Funeral Pre-Planning / Cemetery Plot
<input type="checkbox"/>	<input type="checkbox"/>	Life Insurance Policies
<input type="checkbox"/>	<input type="checkbox"/>	Long-Term Care Insurance Policy
<input type="checkbox"/>	<input type="checkbox"/>	Any Current Beneficiary Elections
<input type="checkbox"/>	<input type="checkbox"/>	Prior Gift Tax Returns
<input type="checkbox"/>	<input type="checkbox"/>	Last Federal Income Tax Return

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