Confidential Long-Term Care Questionnaire

Personal and Financial Information

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This questionnaire is designed to help us gather the information necessary 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.

We have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. 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.

PERSONAL INFORMATION

(Please Print)

If you are completing this questionnaire for someone other than yourself and/or your spouse:

Name of person completing questionnaire: _____

Relationship to person(s) below: _____

Home address _____ City _____ State _____ Zip _____

Day-time telephone: (___) _____ Email: _____

WHO REFERRED YOU TO US? _____

Client # 1 (Husband or Single Male)

Full Legal Name _____

What other names have you also been known as _____

What name do you use on legal documents _____ E-Mail _____

By what name would you like to be addressed by our staff? _____

County of Residence _____ Birthdate _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone: (___) _____ Cell:(___) _____ Fax:(___) _____

Employer _____ Position _____ Business Telephone(___) _____

Business address _____ City _____ State _____ Zip _____

☐ Married: Date _____ ☐ Divorced: Date _____ ☐ Widowed: Date _____ ☐ Single

Client # 2 (Wife or Single Female)

Full Legal Name _____

What other names have you also been known as _____

What name do you use on legal documents _____ E-Mail _____

By what name would you like to be addressed by our staff? _____

County of Residence _____ Birthdate _____ Social Security Number _____

Home address _____ City _____ State _____ Zip _____

Home telephone: (___) _____ Cell:(___) _____ Fax:(___) _____

Employer _____ Position _____ Business Telephone(___) _____

Business address _____ City _____ State _____ Zip _____

☐ Married: Date _____ ☐ Divorced: Date _____ ☐ Widowed: Date _____ ☐ Single

CHILDREN

Please list all children of present and prior marriage (if any) and indicate if any children are deceased by placing a "D" next to their name, and note if that child left any surviving children. Please check the *Special Needs* box if a child has "special needs." (For example, think about health and general financial status, including needs and abilities.)

Name and Address	Parent (Client 1,2, both)	Birthdate	Special Needs (Blind, Mentally Handicapped, etc.
			☐
			☐
			☐
			☐
			☐

Are any children currently residing with Client #1 or Client #2? **_____Yes _____No**

Unavailable Children

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

_____

_____

HEALTH RELATED PROBLEMS

Client 1: _____

_____

_____

Client 2: _____

_____

"CAPACITY"

Are there any known problems with memory or understanding? Yes ___ No ___

If yes, please describe the nature of the problem: _____

_____

_____

IMPORTANT FAMILY QUESTIONS

Please Check Y-yes or N-no for Your Answer	Husband		Wife	
	Y	N	Y	N
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?				
Does either individual provide primary or other major financial support to adult children or any other adult?				
Have either individual been divorced?				
Is either individual making payments pursuant to a divorce or property settlement agreement? (Please furnish a copy)				
Have either individual ever filed a Federal, State gift or estate tax return? (Please furnish a copy)				
Have either individual completed previous Medical Powers of Attorney or Living Wills? (Please furnish a copy)				
Have either individual completed previous wills, trusts, or estate planning? (Please furnish copies of these documents)				
Is either individual the beneficiary of any trust now?				
Have either individual served in the military and is eligible for veterans benefits?				
Does either individual have a burial plot or funeral contract? (Please furnish a copy)				
Does either individual have long-term care insurance?				
Is either individual currently receiving long-term care? (If yes, please complete Long-Term Care section on page 4)				
Have you or any of your family members ever been a Plaintiff in any lawsuit or legal complaint (other than divorce)? If yes, please specify:_____				

PROFESSIONAL ADVISORS

Name of CPA: _____ Company_____

Phone # _____ Address _____

Name of Fin. Advisor: _____ Company _____

Phone # _____ Address _____

PHYSICIAN'S INFORMATION

Personal Physicians: _____ _____

Address: _____ _____

_____ _____

Business Telephone: _____ _____

STATEMENT OF GOALS

_____

_____

_____

_____

_____

Long-Term Care (LTC)

What was the date of entry into the nursing home or facility or the date the home care was started?

Husband (or Single Male):_____ Wife (or Single Female): _____

Name of the LTC facility/provider: _____

Address:_____Telephone: _____

Administrator (or other contact): _____

Is the individual likely to return home or expected to return home? Yes ___ No ___

Does the facility accept Medicaid? Yes ___ No ___

Was the stay in the facility or the home care immediately preceded by a hospital stay? Yes ___ No ___

How long was the hospital stay? _____ days/months

RESPONSIBLE PERSONS

Who now has "assistance" responsibilities (i.e., are any family members or other individuals providing custodial or other types of care to the individual needing assistance?)

Name: _____ Relationship _____

Address: _____ Phone: _____

Name: _____ Relationship _____

Address: _____ Phone: _____

MONTHLY COST OF LIVING

	Husband/Male	Wife/Female	Both
Housing			
If home is owned, estimate total cost of mortgage, taxes, utilities, phone, etc.	$_____	$_____	$_____
If rented, estimate monthly rental/lease expense (include maintenance fees)	$_____	$_____	$_____
Insurance Premiums (monthly)			
Health	$_____	$_____	$_____
Long-term care	$_____	$_____	$_____
Life	$_____	$_____	$_____
Other (specify)			
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
Non-covered medications	$_____	$_____	$_____
Other (specify)			
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
TOTALS	$_____	$_____	$_____

INSTRUCTIONS FOR COMPLETING THE *FINANCIAL INFORMATION* CHECKLIST

General Headings

This *Financial Information* Checklist is designed to help you list all the property owned by the person needing long-term care, how it is titled, and its value. If there is more property than can be listed on this checklist use extra sheets of paper to list additional property. Any reference to "you" on this financial information checklist refers to Client 1 and/or Client 2, the person(s) needing long-term care.

Type

Immediately after the heading for each kind of property is a brief explanation of what property you should list under that heading.

"Owner" of Property

How property is owned is extremely important for purposes of properly designing and implementing your plan. For each property category, there is a column titled "Owner." When filling in this column, please use the following abbreviations:

For Property Owned By:	**With:**	**Use:**
Single	If you are single and you own property in your name only, use	I
Client #1's	No other person	C1
Client # 2's	No other person	C2
Joint Tenancy	A spouse	JTS
Joint Tenancy	Someone other than a spouse	JTO
Tenancy in Common	A spouse	TCS
Tenancy in Common	Someone other than a spouse	TCO
Unknown	If you cannot determine how the property is owned	?

I. ASSETS

CASH ACCOUNTS

TYPE: Checking Account "CA" Savings Account "SA" Certificate of deposits "CD"

Name of Institution / Branch Address	Type	Account #	Owner	Amount
*				
*				
*				
*				
*				
*				

TOTAL $_____

Are any funds directly deposited in any of the above accounts? Yes ☐ No ☐

Note: If Account is in your name (or your spouse's name) for the benefit of a minor, please specify and give minor's name.

INVESTMENT ACCOUNTS

*** IRA's or Annuities should be listed later ***

TYPE: Money market "MM", Investment "I", Cash Management "CM" or other account that is in a street name

Name of Brokerage Firm Phone # & Address of Broker	Type	Account #	Owner	Amount
*				
Phone #(___)	Address:			
*				
Phone #(___)	Address:			
*				
Phone #(___)	Address:			

(continued on reverse)

Name of Brokerage Firm **Phone # & Address of Broker**	**Type**	**Account #**	**Owner**	**Amount**
*				
Phone #( )	Address:			
*				
Phone #( )	Address:			

Total $_____

STOCKS & STOCK OPTIONS

TYPE: **STOCK** in publicly owned corporations which is a stock traded on an exchange or over the counter. (Stock owned in family or nonpublicly traded companies should be listed under "*Corporate Business and Professional Interests*" Stocks held in a street name or investment account should be listed under "*Investment Accounts*"). Also please list **STOCK OPTIONS** of *any type* from any company here.

Company Name **Address & Phone #**	**Owner**	**Number of Shares**	**Fair Value Market**
*			
Phone ( )			
*			
Phone ( )			
*			
Phone ( )			
*			
Phone ( )			
*			
Phone ( )			
*			
Phone ( )			

Total $_____

BONDS

TYPE: US Savings Bonds, Corporate, Municipal, etc., (indicate type below).

Type	Owner	Face Value

Total $_____

PERSONAL EFFECTS

Indicate major personal effects such as motor vehicles, boats, and all other valuable nonbusiness personal property. Please note items of special value such as antiques, jewelry, or other collectibles.

Type	Owner	Value	Is there a loan against the asset
Home Furnishings			
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Total $_____

Property and Casualty Insurance Agent(s): _____

Types of Insurance (Home, Auto, Umbrella, etc.): _____

RETIREMENT PLANS

TYPE: Pension (P), Profit Sharing (PS), H. R. 10, IRA, SEP, 401(k) (Indicate type below)

Company Name Address and Phone #	Type of Plan	Value	Beneficiary upon Your Death	Are you currently receiving benefits from this plan
				☐ Yes ☐ No
Phone # (___)	Account #:			
				☐ Yes ☐ No
Phone # (___)	Account #:			
				☐ Yes ☐ No
Phone # (___)	Account #:			
				☐ Yes ☐ No
Phone # (___)	Account #:			

Total $_____

LIFE INSURANCE POLICIES

TYPE: Term, whole life, split dollar, group life, (indicate type of policy below. If a corporation or company owns the policy or pays the premium on the policy, write "Corporation").

Company_____ Policy Number_____
Type_____ Insured_____
Owner_____ Primary Beneficiary_____
Secondary Beneficiary_____ Agents Name_____
Address_____ Phone #(___)_____
Face Amt._____ Cash Value_____

Company_____ Policy Number_____
Type_____ Insured_____
Owner_____ Primary Beneficiary_____
Secondary Beneficiary_____ Agents Name_____
Address_____ Phone #(___)_____
Face Amt._____ Cash Value_____

Company_____ Policy Number_____
Type_____ Insured_____
Owner_____ Primary Beneficiary_____
Secondary Beneficiary_____ Agents Name_____
Address_____ Phone #(___)_____
Face Amt._____ Cash Value_____

Total $_____

ANNUITIES

Company_____ Policy Number_____
Type_____ Annuitant_____
Owner_____ Primary Beneficiary_____
Secondary Beneficiary_____ Agents Name_____
Address_____ Phone #(___)_____
Face Amt._____ Cash Value_____

Company_____ Policy Number_____
Type_____ Annuitant_____
Owner_____ Primary Beneficiary_____
Secondary Beneficiary_____ Agents Name_____
Address_____ Phone #(___)_____
Face Amt._____ Cash Value_____

Total $_____

SAFETY DEPOSIT BOXES

Name of Institution_____ Address_____
Box Number(s)_____Persons with Access_____

Do you have a Safe or Lock Box other than a Safety Deposit Box? Yes___ No___
Location (Home, Office, etc.)_____
Who has access to this Safe or Lock Box? _____

MORTGAGES, NOTES, & OTHER RECEIVABLES

TYPE: Promissory notes payable *to you*; other monies owed *to you - bring a copy of any promissory notes.*

Name of Debtor	Date Due	Owed to	Current Balance

Total $_____

PARTNERSHIP INTERESTS

Please list the percentages that you own and *bring the Partnership Agreement.*

Name of Partnership_____
Owners_____ Value_____
Who holds Partnership papers_____ Phone #(___)_____

Name of Partnership_____
Owners_____ Value_____
Who holds Partnership papers_____ Phone #(___)_____

Total $_____

CORPORATE BUSINESS AND PROFESSIONAL INTEREST

Privately owned (nonpublicly traded) stock: *Please bring a copy of any Buy/Sell agreements*

Company_____ Address_____ Phone #.(___)_____
Number of Shares_____ % of Ownership _____
Owner_____ Value_____
Is there a Buy/Sell Agreement ☐ Yes ☐ No Is this an "S-Corporation" ☐ Yes ☐ No

Company_____ Address_____ Phone #.(___)_____
Number of Shares_____ % of Ownership _____
Owner_____ Value_____
Is there a Buy/Sell Agreement ☐ Yes ☐ No Is this an "S-Corporation"? ☐ Yes ☐ No

Total $_____

SOLE PROPRIETORSHIP BUSINESS AND PROFESSIONAL INTERESTS

TYPE: All of the assets used by you in a sole proprietorship type of business ownership.

Name of Business	**Description of Business**	**Owner**	**Value**

Total $_____

OIL, GAS AND MINERAL INTERESTS

TYPE: Lease, overriding royalty, fee mineral estate, working interest, pooling agreement, etc.

Please provide copy of Agreement, Certificate or Deed

Company_____ Type_____ Name_____
Address_____ City_____ State_____ Zip_____
County_____ Phone #_____
Owner_____ Value_____

Company_____ Type_____ Name_____
Address_____ City_____ State_____ Zip_____
County_____ Phone #_____
Owner_____ Value_____

Total $_____

ANTICIPATED INHERITANCE, GIFT, OR LAWSUIT JUDGMENT

TYPE: Gifts or inheritances that you expect to receive at some time in the future (including existing trust funds); or monies that you anticipate receiving through a judgment in a lawsuit.

Description	**Value**
_____	_____
_____	_____
_____	_____
_____	_____

Total $_____

REAL ESTATE

TYPE: Land, buildings, homes and time shares. TYPE OF OWNERSHIP: Joint Tenants with survivorship rights (JTWROS), Tenants in common (TC)

Please provide a copy of the Deed relating to each property and a copy of the most recent tax bill.

<u>Residence (Homestead) – Owned</u> ***(If rented, skip to section below titled "Residence – Rented")***

Address	**Owner**	**Fair Market Value**
_____	_____	_____

City_____ State_____ Zip_____
County_____ Outstanding Mortgage Amount: _____
Is it a reverse mortgage? Yes ___ No ___

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 ___

If yes, 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 ___

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

_____

_____

Do the individuals needing care have any living children who are disabled? Yes ___ No ___

If yes, please describe the nature of the disability: _____

_____

_____

Has the individual's sibling (if any) lived in the home for at least one (1) year? Yes ___ No ___
If yes, does the sibling still reside in the home? Yes ___ No ___

Residence – Rented If the individual rents their home:
Monthly rent: _____ Is the rent being paid by someone else? Yes ___ No ___
By whom ? _____
How much of the rent do they pay? _____
Type of Rental: Single Family _____ Apartment _____
Residential Care _____ Senior Housing _____
Assisted Living _____

Other Real Estate

Address	**Owner**	**Fair Market**
_____	_____	_____

City_____State_____Zip_____
County_____ Outstanding Mortgage Amount: _____

_____	_____	_____

City_____State_____Zip_____
County_____ Outstanding Mortgage Amount: _____

_____	_____	_____

City_____State_____Zip_____
County_____ Outstanding Mortgage Amount: _____

TRANSERS/GIFTS

Did the individual(s) transfer property to someone other than the spouse within the past thirty-six (36) months (including charities)? If yes, please provide the following information:

Recipient	Amount	Date

Were gift tax returns filed on any of these gifts? (Please provide copies if possible) Yes ___ No ___

Did the individual(s) transfer property into a Trust or was property transferred by them or on their behalf from a Trust within the past sixty (60) months? If yes, please provide the following information:

Name of Trust	Amount	Date

OTHER ASSETS AND DEBTS

TYPE: Any property or debts (including credit cards) that have not been listed in any other category.

Description	Value

Total Other Assets $_____

Total Other Debts $_____

II. INCOME- MONTHLY

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

Fixed Monthly	Husband/Single Male	Wife/Single Female	Joint
Social Security	$_____	$_____	$_____
IRA or 401(k)	$_____	$_____	$_____
Pension	$_____	$_____	$_____
Other (describe)			
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
Non-Fixed Monthly			
Interest	$_____	$_____	$_____
Dividends	$_____	$_____	$_____
Other (describe)			
_____	$_____	$_____	$_____
_____	$_____	$_____	$_____
TOTAL INCOME:	**$_____**	**$_____**	**$_____**

- **Affirmation: The undersigned hereby states and affirms that the information contained in this Confidential Long Term Care Questionnaire is an accurate and complete record of all assets, liabilities and account information, and that The Wiewel Law Firm (the "Firm") will be relying on this information in its preparation and counseling regarding long term care and Medicaid planning if the undersigned becomes a Client of the Firm. If the undersigned becomes a Client of the Firm, any information that would render this information inaccurate or incomplete will be provided to the Firm in writing within ten (10) days of the date the undersigned becomes aware of the inaccuracy or incompleteness of it.**

Date: _____ **Date: _____**

_____ _____

Client **Client**