

Prepared by:
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Long Term Care Planning Questionnaire
(Married Individual)

Please complete the following form to the best of your ability in advance of your appointment with our office. Completing this form may be overwhelming to you and doing so is not required for your appointment, however, completing the form will help us properly advise you, and will reduce the amount of time needed for the appointment. **JUST DO THE BEST YOU CAN!** In addition to completing this form, if at all possible please bring with you any documentation that supports the information listed on this form such as:

- ◆ Copies of all estate planning documents such as wills, trusts, powers of attorney, durable powers of attorney, health care powers of attorney and/or living wills
- ◆ Written documentation of current income from income source such as award letters or current check stubs or deposit advice summaries
- ◆ Copy of any pre-need burial plan contracts and/or agreements
- ◆ Deeds or copies of deeds for real property owned and current mortgage amount
- ◆ Copies of purchase agreements and current amount owed on vacation properties (time shares)
- ◆ Copies of vehicle titles and current amount owed
- ◆ Copy of military discharge papers, if applicable
- ◆ Copy of un-expired immigration or naturalization document, if applicable
- ◆ Copies of life insurance policies and current cash surrender value
- ◆ Copies of current statements for all financial accounts (bank and/or investment accounts, IRA, CD's, etc.)
- ◆ Copies of annuity contracts and current cash value
- ◆ Copy of marriage license
- ◆ Copy of birth certificate and Social Security card for person at risk of long term care
- ◆ Copy of long term care policies and/or health insurance policies & identification cards including Medicare card
- ◆ Any other documents you feel may be helpful in determining the value and title to the applicant and spouse's resources and income

1. Prospective Client Information (person who is filling out this form)

Name: _____
Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Fax Number: _____ E-mail Address: _____
Relation to Person in need of care: _____

2. Person at Risk of Needing Long Term Care (hereinafter "person")

Name: _____
Date of Birth _____ Place of Birth: _____
Age : _____ SSN: _____
Permanent Address: _____

Phone Number: _____ Cell Phone: _____
Fax Number: _____ E-mail Address: _____
Present Location: _____
Phone: _____
Type of facility: _____
Date entered facility: _____
Medicare days used, if nursing home placement: _____
On hospice? Yes No
Paid for placement through what date: _____
Describe future placement plan: _____

U.S. Citizen? Yes No

Any previous marriages of person? YES NO
(If "yes", please complete)

Name of former spouse	Terminated by Divorce or Death?	Date of termination
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Person's spouse

Name: _____
Date of Birth: _____ Age: _____ Social Security #: _____
Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Fax Number: _____ E-mail Address: _____

Any previous marriages of spouse?

YES

NO

(If "yes", please complete)

Name of former spouse

Terminated by
Divorce or Death?

Date of termination

4. Children of current or former relationships:

a. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Married? Yes No
Child's Spouse's Name: _____
Child's Parents' Names: _____

b. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Married? Yes No
Child's Spouse's Name: _____
Child's Parents' Names: _____

c. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Married? Yes No
Child's Spouse's Name: _____
Child's Parents' Names: _____

d. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
Married? Yes No
Child's Spouse's Name: _____
Child's Parents' Names: _____

e. Name: _____
 Birthdate: _____
 Address: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Email address: _____
 Married? Yes No
 Child's Spouse's Name: _____
 Child's Parents' Names: _____

f. Name: _____
 Birthdate: _____
 Address: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Email address: _____
 Married? Yes No
 Child's Spouse's Name: _____
 Child's Parents' Names: _____

5. Does the person have any disabled children? YES NO

a. If so, what are their name(s)? _____

b. If so, what is the type of disability, and has a S.S.A. disability determination been made? _____

6. If any children of person are deceased, indicate name(s), and year of death:

7. Living Parents of Person and Person's Spouse

<u>Name</u>	<u>Age</u>	<u>Address</u>	<u>Home phone number</u>	<u>Parent of person or person's spouse</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

8. **Living Grandchildren of person and person's spouse** (If grandchildren are no longer living with their parents, please list the current address and phone number)

<u>Name of Granchild</u>	<u>Age</u>	<u>Grandchild of person or person's spouse</u>	<u>Name of Parents</u>	<u>Address</u>	<u>Phone Number</u>

9. **Living Brothers and Sisters of person and person's spouse**

<u>Name</u>	<u>Age</u>	<u>Address</u>	<u>Home phone number</u>	<u>Sibling of person or person's spouse</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

10. **Legal Documents of person and spouse:**

	<u>Person</u>	<u>Spouse</u>
a. Do they have a will?	_____	_____
b. Do they have a trust?	_____	_____
c. Do they have a General Power of Attorney or a Power of Attorney for Financial Decisions?	_____	_____
d. Do they have a Power of Attorney for Health Care Decisions?	_____	_____
e. Do they have a Mental Health Care Power of Attorney?	_____	_____
f. Do they have a living will?	_____	_____
g. Do they have a pre-hospital medical care directive?	_____	_____

11. **Medical Background of Person:**

- a. Does it appear that the person may need long term care in the near future?
 _____ Yes _____ No

- b. Describe the specific medical condition necessitating long term care and how advanced it is: _____

- c. Describe the person's other health problems: _____

- d. What therapies is the person receiving? _____

- e. What medications is the person taking and for what condition?

- f. Please describe the person's ability to do the following activities (i.e. prompting and/or verbal instructions or partial hands on assistance, or total assist)
1. Ambulate _____
 2. Transfer _____
 3. Toilet _____
 4. Eat and prepare food _____
 5. Groom _____
 6. Bathe _____
 7. Dress _____
- g. Does the person appear to be mentally incapacitated? ____ Yes ____ No
 If so, what are the indications? _____

- h. Do you believe the person is able to engage in financial or legal planning, including doing estate planning documents?
 ____ Yes ____ No ____ Maybe
- i. Does the person wander or is he/she aggressive in any way? ____ Yes ____ No
 If so, describe: _____

- j. Has the person been evaluated by a psychiatrist, neurologist, or psychologist?
If so, by whom, what type of doctor, and when was last evaluation done?

12. Medical Background of Person's Spouse:

- a. Please describe the overall mental and physical condition of the spouse:

- b. Is the spouse at risk of needing long term care? _____ Yes _____ No
Is so, please describe the indications: _____

- c. Do you believe the spouse is able to engage in financial or legal planning,
including doing estate planning documents?

_____ Yes _____ No _____ Maybe _____

13. Health Insurance:

Do the person and spouse have health insurance? _____ Yes _____ No

	Person Yes or No	Spouse Yes or No	Company
Long Term Health Care Insurance	_____	_____	_____
Medicare coverage (Part A)	_____	_____	_____
Medicare coverage (Part B)	_____	_____	_____
Medicare Advantage Plan (HMO)	_____	_____	_____
Medi-gap/Medicare Supplement	_____	_____	_____
Medicare Prescription DrugPlan	_____	_____	_____
AHCCCS	_____	_____	_____
ALTCS	_____	_____	_____
Tri-Care	_____	_____	_____
Other Insurance	_____	_____	_____

14. Veteran Information:

Is the person or spouse a Veteran? Yes No

If so, indicate whether person or spouse: _____

a. Service History:

Dates of Enrollment: _____

Date of Discharge: _____

Served during war time? Yes No

If so, name of war? _____

Honorable Discharge: Yes No

Branch of the Military: _____

Grade, Rank or Rating: _____

Service Number: _____

Injured while in the service: Yes No

Seriously ill while in the service and continuing issues exist:

Yes No

Mental or physical condition that may be related to military service:

Yes No

Permanently and totally disabled due to military service:

Yes No

b. V.A. Payments:

Is the person or spouse receiving, or will they receive, retired or retainer pay that is based

on military service? _____

If the person or spouse is currently receiving such compensation, what is the amount paid to them _____

Is the person's or spouse's retirement based on:

___ Length of service ___ Disability ___ Temporary Disability Retired

Will the person or spouse receive, or have they received, any of the following benefits:

___ Lump Sum Readjustment Pay

___ Separation Pay

___ Special Separation Benefit

___ Voluntary Separation Incentive

___ Disability Severance Pay (name of disability: _____)

___ Other _____

15. Monthly Income:

	<u>Person</u>	<u>Spouse</u>
a. Monthly Paycheck (Gross)	_____	_____
b. Monthly paycheck (Net)	_____	_____
c. Rental income	_____	_____
d. Private pension and retirement (Gross)	_____	_____
Private pension and retirement (Gross)	_____	_____
Private pension and retirement (Gross)	_____	_____
Private pension and retirement (Gross)	_____	_____
e. V.A. pension (Gross)	_____	_____
f. Social Security Income (Gross)	_____	_____
g. Social Security Income (Net)	_____	_____
h. Dividends and interest income including reinvested dividends and bank account interest	_____	_____
i. Disability and unemployment pay	_____	_____
j. IRA distributions	_____	_____
k. Third party trust distributions*	_____	_____
l. Annuity	_____	_____
m. Note/deed of trust income	_____	_____
n. Other	_____	_____
TOTAL MONTHLY INCOME:	_____	_____

*If person or spouse is receiving trust distributions from a trust other than their own, please describe the trust, i.e. amount and type of trust assets, source of trust, trustee, and right to distributions:

16. Resources of person and spouse:

a. **Real Property:**

Address	Names on Deed/Type of Ownership	Market Value
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$

Tax Assessed Value	Balance of Mortgage (if any)	Purchase Price
\$	\$	\$
\$	\$	\$
\$	\$	\$
\$	\$	\$
\$	\$	\$
\$	\$	\$

b. **Household Goods and Personal Effects:**

1. **Total Estimated Value:** \$ _____

2. **Valuable Collections:**

Description	Value
	\$
	\$
	\$
	\$

c. **Vehicles (including automobiles, mobile homes, golf carts and boats):**

Description	Names on Title	Value	Balance on Loan
		\$	
		\$	
		\$	

d. **Burial plots/niches owned by person and/or spouse:**

For person: Yes No

For spouse: Yes No

For immediate family: Yes No

Names of plot beneficiaries: _____

Location of plots/niches owned by person and/or spouse:

e. **Burial Funds or Plans owned by person and/or spouse:**

For person: Yes No

For spouse: Yes No

1) Describe plans: _____

2) Revocable or irrevocable: _____

3) Current value: _____

4) Balance owing: _____

f. Life Insurance:

Company	Owner	Insured Person	Policy Number	Beneficiary	Death Benefit	Cash Value

g. IRA's, 401(k)'s, Keogh, qualified annuities or other retirement plans with cash value:

Company	Owner	Type of Account	Account Number	Beneficiary	Cash Value	Current Distribution

h. Annuities (non-qualified, i.e. funded with after tax dollars):

Company	Owner	Policy Number	Beneficiary	Death Benefit	Surrender Value	Current Distribution

Describe annuity withdrawal penalties/rights if any, and penalty exceptions, if any: _____

i. Bank accounts and Money Market accounts:

Bank	Type (i.e. savings, checking)	Account Number	Names on Account (Title)	Balance	Interest Rate

j. Certificates of Deposit:

Bank	Name on Account	Account Number	Balance	Interest Rate	Maturity Date

k. Promissory Notes, payable to person or spouse:

Payor	Payee	Secured by Deed of Trust (Yes/No)	Original Principal Amount	Current Amount Owed

l. Stocks, bonds, mutual funds held in brokerage account:

Company	Names of Owners	Type of Investment	Account Number	Total Value

m. Stocks and Mutual Funds (held by certificate):

Description	Names of Owners	# of Shares	Share Value	Total Value	Monthly Dividend	Purchase Price per Share

n. Bonds, and treasury certificates (held by certificate):

Description	Names on Bonds	Serial Number	Value	Monthly Dividends	Maturity Date

o. Partnership:

Description	Ownership	Value	Maturity Date

p. Other resources:

Description	Title	Value	Income

17. Transfer of assets: Has the person and/or spouse transferred any asset to an individual for less than fair market value within the last sixty months, such as large financial gifts (\$500.00 or more), or transferred title to assets to another person within the last sixty months? Yes No

Type of property transferred	Value then	Transferee	Date Transferred

18. Outstanding debts owed by person and/or spouse:

To whom owed:

Amount due:

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

19. Monthly expenses for out of home or in-home care for person and spouse:

Type of Care Expense

Monthly Amount

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Total Care Expenses:

\$ _____

20. Other estimated monthly expenses, if applicable:

Type of Expense	Monthly Amount
Mortgage or rent	\$ _____
APS/electric	\$ _____
Gas/utility	\$ _____
Phone	\$ _____
Phone	\$ _____
Water	\$ _____
Food	\$ _____
Postage	\$ _____
Car Insurance	\$ _____
Medical and dental insurance premiums	\$ _____
Prescriptions	\$ _____
Gas for auto	\$ _____
Property taxes	\$ _____
Home insurance	\$ _____
Clothing	\$ _____
Entertainment	\$ _____
Life insurance premiums	\$ _____
Gifts/donations	\$ _____
Newspaper/magazines	\$ _____
Cable T.V.	\$ _____
Automobile maintenance/repair	\$ _____
Home maintenance/repair	\$ _____
Vacations	\$ _____
Unreimbursed medical/dental expenses	\$ _____
Income Taxes	\$ _____
Miscellaneous (supplies, etc.)	\$ _____
Credit Card Debt	\$ _____
Hair	\$ _____
Other: _____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL	\$ _____

21. Does the person/spouse currently have a financial advisor? Yes No
 If so, please list their name, email address and telephone number:

22. Does the person /spouse currently have an insurance agent for long term care insurance, or have they contacted one? Yes No

If so, please list their name, email address and telephone number:

23. Does the person/spouse currently have an accountant? Yes No
If so, please list their name, email address and telephone number:

24. Does the person/spouse currently have a primary care physician?
 Yes No

If so, please list their name and telephone number:

25. Does the person/spouse have a treating neurologist, psychologist or psychiatrist?
 Yes No

If so, please list their names, and describe the type of doctor: _____

26. Is the person or spouse expecting any inheritances in the near future?
 Yes No

If so, how much/and from where?

27. If the person or spouse is not enrolled in Medicare Prescription Drug Coverage and has prescription drug coverage, have you contacted your health insurance company to verify if they have "creditable coverage"? Yes No

If they do not have prescription drug coverage or have it but are dissatisfied and want to know if enrolling in Medicare Part D could save them money on prescription drug costs, please let us know so we can help you determine whether enrolling in Medicare Part D might save them money, and if so, refer you to an agency who will help you select a plan under Medicare Part D that will meet your needs.

Verification

I have provided complete and accurate financial information to the Law Offices of Chester B. McLaughlin, P.C. for the purposes of long term care planning. I understand that the long term care advice, ALTCS application, and terms of the fee agreement will be based upon the information provided in this questionnaire. I understand that any inaccurate or omitted financial information could result in inappropriate legal advice, denial of the ALTCS application, and revision of the terms of the fee agreement.

Date: _____

Client