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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.

The long term care planning advice, the ALTCS application if requested, and the terms of our fee agreement will be based on the assumption of the financial information provided in this questionnaire being complete and accurate.

If possible, please bring to your appointment any documentation that supports the information listed in this questionnaire, 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. **Client:** (person who is filling out this form)

Name: _____
Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Fax Phone: _____ E-Mail Address: _____
Relation to Applicant: _____

2. **Applicant Information:** (person who is at risk of long term care)

Name: _____
Date of Birth: _____ Place of Birth: _____
U.S. Citizen?: _____ Yes _____ No Age: _____
SSN: _____
Permanent Address: _____

Home Phone: _____ Work Phone: _____
Fax Phone: _____ E-Mail Address: _____
Present Location: _____
Phone: _____
Type of facility: _____
Date entered facility: _____
Medicare days used, if nursing home placement: _____
Paid for placement through what date: _____
Date of Marriage: _____ Place of Marriage: _____
Attending interview: _____ Yes _____ No

Previous Marriages:

Terminated by:

Divorce

Death

Date

3. **Spouse Name:**

Age: _____ Date of Birth: _____ SSN: _____
Permanent Address if different than applicant: _____

Home phone: _____ Work phone: _____
Fax Phone: _____ E-Mail Address: _____
Present address if different: _____

Phone: _____
Occupation: _____ U.S. Citizen?: Yes ___ No ___
Place of Birth: _____
Veteran?: _____ Yes _____ No
Attending Interview? _____ Yes _____ No

Previous Marriages:

Terminated by:

Divorce Death Date

4. Children of this marriage:

1. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No

2. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No

3. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No

4. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No

5. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No

6. Name: _____
Birthdate: _____
Address: _____
Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No

5. Do either you or your spouse have any children from a former marriage? _____
_____ Yes _____ No
If Any children deceased, indicate name _____

1) Name: _____
Birthdate: _____
Address: _____

Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No
Child of applicant or spouse? _____

2) Name: _____
Birthdate: _____
Address: _____

Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No
Child of applicant or spouse? _____

3) Name: _____
Birthdate: _____
Address: _____

Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Child of applicant or spouse? _____

4) Name: _____
Birthdate: _____
Address: _____

Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No
Child of applicant or spouse? _____

5) Name: _____
Birthdate: _____
Address: _____

Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No
Child of applicant or spouse? _____

6) Name: _____
Birthdate: _____
Address: _____

Home Phone: _____ Work Phone: _____
Married?: _____ Yes _____ No
Attending interview: _____ Yes _____ No

Child of applicant or spouse? _____

6. Do you have any disabled children? _____
What are their names? _____
If so, what is the type of disability, and has a S.S.A. disability determination been made? _____

7. If any children are deceased, indicated names and whether a child of applicant or spouse. _____

8.

<u>Grandchildren</u>	<u>Age</u>	<u>Name of Parent</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Brothers and Sisters

<u>Applicant</u>	<u>Spouse</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10. Legal Documents:

	<u>Applicant</u>	<u>Spouse</u>
a. Is there a will?	_____	_____
b. Is there a trust/beneficiary of any trust?	_____	_____
c. Is there a Power of Attorney for Financial Decisions?	_____	_____
d. Is there a Power of Attorney for Health Care Decisions?	_____	_____
e. Is there a living will?	_____	_____
f. Is there a pre-hospital medical	_____	_____

care directive?

11. Medical Planning:

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

b. Has the applicant been hospitalized, in a nursing facility or received in-home medical services for a total of 30 consecutive days? If so list dates and providers: _____

c. Describe the medical condition necessitating long term care and the medical treatments being administered and overall health of applicant in general terms: _____

d. Please describe the applicant's ability to do the following activities (i.e. prompting or hands on assistance necessary):

1. Ambulate _____
2. Transfer _____
3. Toilet _____
4. Eat and prepare food _____
5. Groom _____
6. Bathe _____
7. Dress _____

e. Does the applicant appear to be mentally incapacitated? _____ If so, what are the indications? _____

f. Does the applicant wander or is he/she aggressive in any way? _____

g. Describe physical and mental health and mental capacity of the applicant's spouse: _____

h. Is the applicant's spouse at risk of needing long term care? _____. If so, describe the indications: _____

i. Do you have health insurance?

	Applicant Coverage	Spouse	Policy #	Premium Amount
Medicare coverage (Part A)	_____	_____	_____	_____
Medicare coverage (Part B)	_____	_____	_____	_____
Supplemental insurance	_____	_____	_____	_____
Long Term Health Care Ins.	_____	_____	_____	_____
Medi-gap	_____	_____	_____	_____
Medicare Advantage Plan (HMO)	_____	_____	_____	_____
Other Health Insurance	_____	_____	_____	_____

12. **VA** Veteran?: _____ Yes _____ No _____ Who? _____
(Name)

Dates Veteran Served _____

Served during war time ____ Yes ____ No: What War: _____

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

Service History:

Dates of Enrollment: _____

Date of Discharge: _____

Active Duty: _____

Honorable Discharge: ____ Yes ____ No

Branch of the Military: _____

Grade, Rank or Rating: _____

Service Number: _____

If you were injured while in service:

Were you injured while traveling to or from your military assignment?

____ Yes ____ No

When did the injury occur: _____

Where did your injury occur: (City, State, country)

Where were you treated: (name and address of doctor or hospital if known)

With which agency did you file an accident report:

Are you receiving or will you receive retired or retainer pay that is based on military service? _____

If you are currently receiving such compensation, what is the amount paid to you? _____

Is your retirement based on:

____ Length of service ____ Disability ____ Temporary Disability Retired List

Will you receive or have you 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 _____

13. Monthly Income:

	<u>Applicant</u>	<u>Spouse</u>	<u>Joint</u>
a. Monthly Paycheck (Gross)	_____	_____	_____
b. Monthly paycheck (Net)	_____	_____	_____
c. Rental income	_____	_____	_____
d. Pension and retirement (Gross)	_____	_____	_____
e. Pension and retirement (Net)	_____	_____	_____
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 (if income)	_____	_____	_____
k. Trust funds	_____	_____	_____
l. Annuity	_____	_____	_____
m. Note/deed of trust income	_____	_____	_____
n. Other	_____	_____	_____
TOTAL MONTHLY INCOME:	_____	_____	_____

14. **Resources:** Please list all resources that are titled to either the applicant, spouse or a third party whether or not the applicant or spouse has an ownership interest in the property; if either the applicant or spouse's name is on the resource, please list it.

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:**
(Rough estimate)
 \$ _____

1) **Valuable Collections:**

Description	Value
	\$
	\$
	\$
	\$

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

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

- | | Applicant | Spouse | Immediate Family |
|---------------------------------------|------------------|---------------|-------------------------|
| d. Burial plots: (indicate yes or no) | _____ | _____ | _____ |
| e. Burial Funds or Plans: | _____ | _____ | _____ |
| 1) Owner's name(s): | _____ | | |
| 2) Beneficiary: | _____ | | |
| 3) Revocable or irrevocable: | _____ | | |
| 4) Current value: | _____ | | |
| 5) Balance owing: | _____ | | |

f. Life Insurance

Company	Owner	Insured Person	Policy Number	Beneficiary	Death Benefit	Cash Value

g. IRA's, 401(k)'s, Keogh, or other retirement plans.

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

h. Annuities

Company	Owner	Insured Person	Beneficiary	Death Benefit	Cash Value	Policy Number

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

n. Bonds, and treasury certificates individually owned:

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

15. Transfer of assets: Has the applicant or spouse transferred any assets to an individual for less than market value within the last thirty-six months, such as large financial gifts (\$500.00 or more) to family members, or transferring title to assets (if so, please describe)? Also list any transfers (gifts) from a trust revocable or to an irrevocable trust within the last five years.

Property transferred	Value	Transferee	Date Transferred
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____

16. Outstanding Debts:

To whom owed: _____ **Amount due:** \$ _____

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

17. Estimated or current monthly expenses for applicable out of home or in-home care for applicant:

Type of Expense	Monthly Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

18. 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	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL	\$ _____

19. Does the applicant currently have a financial advisor? ____ Yes ____ No. If so, please list their name and address: _____

20. Does the applicant currently have an insurance agent for long term care insurance or have you contacted one? ____ Yes ____ No. If so, please list their name and address: _____

21. Does the applicant currently have an accountant? ____ Yes ____ No. If so, please list their name and address: _____

22. Does the applicant currently have a physician? ____ Yes ____ No. If so, please list physician's name and address: _____

23. Is the applicant or spouse expecting any inheritances in the near future? ____ Yes ____ No. If so, how much? _____

24. Is applicant entitled to and/or receiving benefits for long term care through the Veteran's Administration? ____ Yes ____ No. If so, please describe: _____

25. Are you currently enrolled in a prescription drug plan? Yes ____ No ____
If so, what is the plan? (please bring copy of card and description of coverage)

26. If you are not enrolled in Medicare Part D and have prescription drug coverage, have you contacted your health insurance company to verify if you have "creditable coverage"?
Yes ____ No ____

If you do not have prescription drug coverage or have it but are dissatisfied and want to know if enrolling in Medicare Part D could save you money on prescription drug costs, please complete the following Medicare Questionnaire and worksheet so we can help you determine whether enrolling in Medicare Part D might save you money, and if so, refer you to an agency who will help you select a plan under Medicare Part D that will fit 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

Medicare Questionnaire
if you may be interested in Medicare Part D

1. Are you currently enrolled in Medicare? If so, which parts (A,B,D)?

2. Do you have health insurance in addition to Medicare? If so, please list the company name. _____
Is this a Medicare Advantage Plan (HMO) or Medigap policy? _____
3. Do you have a prescription drug benefit with your current health insurance policy? _____
4. Which prescription drug plan (PDP) covers most or all your prescriptions? _____
5. What pharmacy do you use? _____
6. How far away is it from your home? _____
7. What are the PDP's premiums? _____
8. What are the PDP's Deductibles? _____
9. What are the PDP's copays? _____
10. Have you received a notice from your insurance company notifying you if your drug benefit is creditable coverage (ie. better than, or as good as, Medicare Part D)? _____

Medicare Part D Prescription Drug Worksheet

1. Amount of your current annual out of pocket drug costs with any current insurance drug plan(include annual insurance premiums for drug plan also):

_____ **Line 1**

2. Amount of annual drug costs you will pay for under Medicare Part D plan:

A. Deductible:

\$250 _____

B. 25% of annual remaining drug cost
Between deductible and \$2250:

C. All your drug costs between \$2251
and \$5100(coverage gap):

D. 5% of remaining drug cost above
\$5100(catastrophic coverage):

E. Medicare Prescription Drug Plan
Premium for the year :

\$276 (minimum
amount)

Add lines 2A-2E:

_____ **Line 2**

3. If amount on line 2 is greater than line 1 then you probably will not save money enrolling in Medicare Part D. If amount on line 2 is less than line 1 then subtract this amount from line 1, this is your possible

savings, if you sign up for Medicare Part D. However, your exact savings will depend on what plan you choose.