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**Information For Planning For
Arizona Long Term Care And Your Estate
(Single Individual)**

Please complete the following form to the best of your ability in advance of your appointment with our office so that we will have the necessary information to properly advise you at the time of your appointment. 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 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 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 Information (person who is completing this form)

Client: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Relation to Applicant: _____

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

Applicant: _____

Date of Birth: _____ Place of Birth: _____

Age: _____ SSN: _____

Permanent Address: _____

Home Phone: _____ Work Phone: _____

Present location: _____

Phone: _____

Type of facility: _____

Date entered facility: _____

Medicare days used, if nursing home placement: _____

Paid for placement through what date: _____

Attending interview: _____ Yes _____ No

U.S. Citizen?: _____ Yes _____ No Place of birth

Previous Marriages:

Terminated by:

Divorce

Death

Date

3. Children:

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

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

4. Grandchildren

(Note: If the grandchildren are no longer living with their parents, please provide us with their current addresses and phone numbers)

Name and Address (if applicable)	Age	Name of Parent
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Brothers and Sisters

Name

Address and Phone Number

6. Legal Documents:

Applicant

- 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? _____

7. Medical Planning:

- a. Does it appear that the applicant may need long term care in the near future?
_____ Yes _____ No
- b. Describe the medical condition necessitating long term care and the medical treatments being administered and overall health of applicant in general terms:

- c. 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 _____

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

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

f. Does the applicant have health insurance?

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

8. 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 _____

9. Monthly Income:

	<u>Applicant</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:	_____

10. **Resources:**

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 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	Policy Number	Beneficiary	Death Benefit	Cash Value

i. Bank accounts and Money Market accounts

Bank	Type (i.e. joint 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 or Deeds of Trust, payable to applicant:

Description	Title	Value
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

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

Company	Names on Account	Type of Investment	Account Number	Total Value

m. Stocks and Mutual Funds (Individually owned)

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
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p. Other resources:

Description	Title	Value	Income

11. Transfer of assets: Has the applicant transferred any asset 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 revocable trust or to an irrevocable trust within the last five years.

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

12. Outstanding Debts:

<u>To whom owed:</u>	<u>Amount due:</u>
	\$
	\$
	\$
	\$
	\$
	\$
	\$

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

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

14. 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	\$ _____

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

16. 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: ____

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

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

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

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

21. 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)

22. 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 what 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 you're 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)? _____

11. What medications do you take? Please list name and price you currently pay for each prescription.

12. What is your total monthly income?_____

13. What are your total assets(exclude one home and one car)?

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.