

# LONG TERM CARE PLANNING QUESTIONNAIRE

Main Contact Person \_\_\_\_\_ Date \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

**This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to the appointment. Please also bring any Wills, Trusts, Powers of Attorney, and Real Estate Tax Bills that you currently have.**

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## PERSONAL DATA

**(Husband)**

**(Wife)**

Full Legal Name \_\_\_\_\_

Full Legal Name \_\_\_\_\_

Known as \_\_\_\_\_

Known as \_\_\_\_\_

Birth Date \_\_\_\_\_

Birth Date \_\_\_\_\_

Social Security No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

U.S. Citizen? Yes  No

U.S. Citizen? Yes  No

Veteran? Yes  No

Veteran? Yes  No

If so, when? \_\_\_\_\_

If so, when? \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Numbers \_\_\_\_\_

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**A. HEALTH**

Name of Ill Spouse \_\_\_\_\_

Diagnosis & Prognosis \_\_\_\_\_

Course of Treatment \_\_\_\_\_

Where Ill Spouse Currently Resides \_\_\_\_\_

Name of Well Spouse \_\_\_\_\_

Health of Well Spouse \_\_\_\_\_

Where Well Spouse Currently Resides \_\_\_\_\_

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis \_\_\_\_\_

Is either spouse suffering from any type of blindness? Yes  No

Does either spouse need any assistance with the following (check all that apply):

Eating  Bathing  Dressing  Toileting  Transferring  Maintaining Continence

Does either spouse suffer from a mental disability (i.e. Alzheimer's, etc.)? Yes  No

Is there a family history of mental disability? Yes  No

Has either spouse suffered a stroke or been diagnosed with diabetes? Yes  No

Is there longevity in either spouse's family? Yes  No

Does either spouse still operate a motor vehicle? Yes  No

**B. PHYSICIAN & HEALTH INFORMATION**

Full Name of **Husband's** Primary Physician \_\_\_\_\_

Address \_\_\_\_\_

Full Name of **Wife's** Primary Physician \_\_\_\_\_

Address \_\_\_\_\_

**C. INSURANCE AND STATE ASSISTANCE**

Are you currently on Circuit Breaker Plan or any other state pharmaceutical plan? Yes  No

Do you or your spouse have a Medicare Supplemental Insurance Policy? Yes  No

Do you or your spouse have Long Term Care Insurance? Yes  No

**D. REAL ESTATE**

**Homestead:** Address \_\_\_\_\_ PIN \_\_\_\_\_  
(Can be obtained from Tax Bill)

What did you pay for your current home including any improvements? \$ \_\_\_\_\_

Is there any mortgage, line of credit or reverse mortgage? If so, how much? \$ \_\_\_\_\_

List all names that are currently on the title of the home. \_\_\_\_\_  
\_\_\_\_\_

**Address of any real property other the homestead:**

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

What did you pay for this property including any improvements? \$ \_\_\_\_\_

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

What did you pay for this property including any improvements? \$ \_\_\_\_\_

**Bring copies of all deeds to our meeting. We will need legal descriptions & tax numbers.**

Are any of these properties owned by a Land Trust? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, bring a copy of the trust.

**E. MONTHLY INCOME**

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
<b>TOTAL MONTHLY INCOME</b>	<b>\$ _____</b>	<b>\$ _____</b>

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future?      Yes                   No

Estimate of all interest and dividend income: \$ \_\_\_\_\_

**F. MONTHLY COST OF NURSING HOME**

\$ _____	Monthly Nursing Home Cost
\$ _____	Monthly Health Insurance Premium
\$ _____	Monthly Prescription Cost
\$ _____	Monthly Incontinent Cost
\$ _____	Monthly Other Cost
\$ _____	<b>TOTAL MONTHLY COSTS</b>

The nursing home is paid through \_\_\_\_\_ (month/year).

**G. MONTHLY SHELTER EXPENSES**

**(Please divide annual expenses by 12 and quarterly expenses by 3)**

\$ _____	Rent/Mortgage
\$ _____	Real Estate Taxes
\$ _____	Water
\$ _____	Sewer
\$ _____	Utilities (Heat, Electric & Telephone)
\$ _____	Homeowner's insurance premium
\$ _____	Condominium fees
\$ _____	<b>Total Monthly Housing Expenses</b>

**H. MONTHLY NON-SHELTER LIVING EXPENSES**

\$ _____	Food
\$ _____	Medical (including all pharmacy expenses)
\$ _____	Clothing
\$ _____	Transportation (including auto insurance)
\$ _____	Home Maintenance
\$ _____	Life Insurance Premiums
\$ _____	Health Insurance Premiums
\$ _____	Cable TV
\$ _____	Federal and State Income Taxes
\$ _____	Other
\$ _____	<b>Total Monthly Non-Shelter Living Expenses</b>

**I. ASSETS/LIABILITIES**

Please insert the approximate value of each asset/liability in the appropriate space. Please also notice the next page requesting additional details for your real estate, retirement accounts and life insurance.

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
RESIDENCE (CURRENT ASSESSED VALUE)				
OTHER REAL ESTATE (current value)				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
MUTUAL FUNDS				
STOCKS				
BONDS				
RETIREMENT ACCOUNTS (See details in Section J below)				
CASH VALUE – LIFE INSURANCE				
ANNUITIES				
CLOSELY HELD BUSINESS				
NURSING HOME DEPOSIT				
PERSONAL HOUSEHOLD GOODS				
AUTO MOBILES				
BOATS, CANOES, & TRAILERS				
ANY OTHER ASSETS, OR ASSETS IN A SAFE DEPOSIT BOX				
<b>TOTALS</b>				

**J. RETIREMENT ACCOUNTS**

<b>Company Name</b>	<b>Type of Account (IRA, 401(K), etc.)</b>	<b>Current Value</b>	<b>Owner</b>	<b>Beneficiary (Primary &amp; Secondary)</b>

**K. LIFE INSURANCE**

(Include the cash value of the life insurance on the Life Insurance line for the prior page)

**It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.**

<b>Company Name</b>	<b>Type (Term, whole life, universal)</b>	<b>Death Benefit Value</b>	<b>Face Value</b>	<b>Cash Value</b>	<b>Owner</b>	<b>Insured</b>	<b>Beneficiary (Primary &amp; Secondary)</b>

**L. GIFTS**

Please list gifts made in excess of \$3,000 in any one month, to an individual or group of individuals, within the past 60 months:

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Have you ever filed a Federal Gift Tax Return? Yes  No

If so, please state details \_\_\_\_\_

Have any children received an advance on their inheritance or are any children financially indebted to you? \_\_\_\_\_ If so, please explain. \_\_\_\_\_

Does anyone else owe you money? \_\_\_\_\_ If so, please explain. \_\_\_\_\_

**M. CHILDREN (if applicable)**

Does the Husband have any children by a previous marriage? Yes  No

Does the Wife have any children by a previous marriage? Yes  No

Are all of your children in good health? Yes  No

Are any of your children blind or disabled? Yes  No

Have all of your children completed their education? Yes  No

Are any of your children receiving SSI or other forms of government entitlement?  
Yes  No

Do any of your family members have any problems with alcoholism, drug addiction, or AIDS?  
Yes  No

Do any family members have trouble with their own finances? Yes  No

Do any of your children live with you in your home? Yes  No

If yes, name of child \_\_\_\_\_

CHILD'S NAME	ADDRESS (WITH ZIP CODE )	PHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

**N. FUNERAL/CEMETARY**

Do you own cemetery lots? \_\_\_\_\_ If so, where? \_\_\_\_\_

Have you prepaid any other funeral or burial expenses? \_\_\_\_\_

If so, please bring a copy of the documents from the purchase.

**O. MISCELLANEOUS**

Do you have any other legal issues that I should be aware of?      Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**P. REFERRAL**

Who referred you to this office?

Name \_\_\_\_\_

Address \_\_\_\_\_

**Q. CERTIFICATION**

The undersigned hereby represents to the Strohschein Law Group, LLC, and each of its attorneys, that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

**Signature of Client or Client Representative:** \_\_\_\_\_

Once completed, please return this form to:  
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St. Charles, Illinois 60175  
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