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.

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 ____

____

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 any 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 a copy of all deeds to our meeting if they are easily accessible. Otherwise, it will be very helpful to have a Property Identification Number from the real estate tax bill.

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	$_______________	$_______________
VA Disability Benefit	$_______________	$_______________
Annuity Income	$_______________	$_______________
Rental Income	$_______________	$_______________
TOTAL MONTHLY INCOME	$_______________	$_______________

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 or ASSISTED LIVING FACILITY

$_______________ Monthly Nursing Home/Assisted Living Cost

$_______________ Monthly Health Insurance Premium

$_______________ Monthly Prescription Cost

$_______________ Monthly Incontinent Cost

$_______________ Monthly Other Cost

$_______________ **TOTAL MONTHLY COSTS**

The nursing home/assisted living facility 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

$_______________ **Total Monthly Housing Expenses**

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

$________________ Total Monthly Non-Shelter Living Expenses

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				
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				
TOTALS				

J. RETIREMENT ACCOUNTS

Company Name	Type of Account (IRA, 401(K), etc.)	Current Value	Owner	Beneficiary (Primary & Secondary

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.

Company Name	Type (Term, whole life, universal)	Death Benefit Value	Face Value	Cash Value	Owner	Insured	Beneficiary (Primary & Secondary)

L. GIFTS

Please list gifts made in excess of $1,000 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, SSDI, Medicare or Medicaid or other forms of government entitlement? Yes ☐ No ☐

Do any of your family members have any issues with mental illness, alcoholism or drug addiction? 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 (Adult and/or Minor)	ADDRESS	PHONE NUMBER	EMAIL ADDRESS

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 ____
____
____

Does the Wife or Husband maintain any digital assets or have an online presence (i.e. online bank accounts, email accounts or digital business holdings)? Yes ☐ No ☐

If yes, please explain ____
____
____

P. REFERRAL

Who referred you to this office? ______________________________________

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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