

LONG TERM CARE PLANNING QUESTIONNAIRE

-SINGLE-

*This form is extremely important.
help me best represent you.*

*Your accuracy and completeness in responding will
Please bring this information with you to the
appointment.*

Date _____

A. PERSONAL DATA

Full Name _____ (print name as shown
on your checks)

Home Phone No. _____ Business Phone No. _____
Extension: _____

E-mail Address _____ Fax _____

Street Address _____

City _____ State _____ Zip Code _____

Birth Date _____

U.S. Citizen? Yes No Veteran? Yes No

If widowed, please list date of death of spouse _____

Was your former spouse a Veteran? Yes No

B. MEDICAL DATA

1. HEALTH

Diagnosis _____

Prognosis _____

Course of Treatment_____

If you are already in a nursing home, please indicate the name of the nursing home and the date first entered

Name of Nursing Home_____

Address_____

Telephone No. _____Date Entered Facility _____

If you are in an Assisted Living Facility, please indicate name of facility and date first entered.

Name of Assisted Living Facility_____

Address _____

Telephone Number _____

Date Entered Facility _____

2. PHYSICIAN

Full Name of Primary Physician_____

Address_____

City_____ State_____ Zip _____

Telephone Number_____

3. HEALTH INSURANCE

Name of Health Insurance Company_____

Is this a Medicare Supplement Policy? Yes No

Monthly Premium_____

4. LONG TERM CARE INSURANCE

Do you have long term care insurance? Yes No

Name of Company _____

Monthly Premium _____

C. MONTHLY INCOME

Social Security Benefits
(include \$ Medicare Part B Deduction) \$ _____

Retirement Benefits (Gross) \$ _____
\$ _____

Veterans Disability Income \$ _____

Annuity Income \$ _____

Rental Income \$ _____

Gross Pension Amount \$ _____

TOTAL MONTHLY INCOME \$ _____

D. MONTHLY COST OF NURSING HOME/ASSISTED LIVING

Monthly Facility Cost \$ _____

Monthly Prescription Cost \$ _____

Monthly Incontinent Cost \$ _____

Monthly Other Cost \$ _____

Total Monthly Cost \$ _____

The facility is paid through _____ (month/year).

E. GIFTS

Have you made gifts to an individual or group of individuals, or to a trust within the past 60 months? Yes No

If yes, list below:

Recipient _____ Date _____ Amount _____

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 provide a copy.

F. LIFE INSURANCE

Name of Insurance Company _____

Policy # _____

Address _____

City _____ State _____ Zip _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____

Policy # _____

Address _____

City _____ State _____ Zip _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____

Policy # _____

Address _____

City _____ State _____ Zip _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

G. CHILDREN

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail _____

Date of Birth _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail _____

Date of Birth _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail _____

Date of Birth _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail _____

Date of Birth _____

Are all of your children in good health? Yes No

Are any of your children blind? Yes No

Are any of your children disabled? Yes No

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

Do any of your family members have any problems with:

Aids? Yes No

Drug Addiction? Yes No

Alcoholism? Yes No

Spendthrift? Yes No

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

If yes, name of child _____

Does a sibling live in your home with you? Yes No

If yes, name of sibling _____

H. ASSETS/LIABILITIES

Please insert the value of each asset in the appropriate space.

ASSET/LIABILITY	ASSET TOTAL	NAME ON ACCOUNT
PERSONAL EFFECTS		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ (Obtain from Tax Bill)		
OTHER REAL ESTATE		
AUTOMOBILE(S)		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
IRA		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
TOTAL		

Do you have any liabilities? Please list

What did you pay for your current home, including any improvements? _____

Address of any real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

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

(2) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

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

Name of Homeowner's Insurance Company

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Policy No. _____

I. MISCELLANEOUS

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

If yes, please explain

J. REFERRAL

By Whom Were You Referred To This Office?

Name _____

Street Address _____

City _____ State _____ Zip _____

K. CERTIFICATION

The undersigned hereby represents to Jo-Anne Herina Jeffreys, Esq., PA, 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:
