Long-term Care Planning Questionnaire (Married)

It is important that you complete this questionnaire accurately and thoroughly. Please use full legal names and print them legibly. Please bring the completed questionnaire and the requested information with you to your appointment. This information may be used to prepare planning documents.

A. CONTACT PERSON

Name ____
Address ____
City __________________________ State _______ Zip _______
Home ______________ Business _______________ Fax ________________
E-Mail Address _______________________ Cell __________________

B. PERSONAL INFORMATION

	Husband	Wife
Full Name	________________________	______________________________

Address ____
City ________________________ State _______ Zip ___________
Telephone No.__________________ Cell No. ___________________

	Husband	Wife
Birth Date	_________________	___________________
Place of Birth	____________________	_________________________
Last Grade Completed	__________________	_________________________
Social Security No.	_________________	___________________
Date of Marriage	_____________________	
U.S. Citizen?	Yes ☐ No ☐	U.S. Citizen? Yes ☐ No ☐
Veteran?	Yes ☐ No ☐	Veteran? Yes ☐ No ☐
If Veteran, dates of service	_______________	_______________________

How did you hear about Oast & Hook or who referred you to this office? ________________________________

C. CHILDREN (please print full legal names so they are legible)

Name	Address	Telephone Number Fax Number Email Address	SSN
		T: F: E:	
		T: F: E:	

		T: F: E:	

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 your children in good health? Yes ☐ No ☐
Are any of your children blind? Yes ☐ No ☐
Are any of your children disabled? Yes ☐ No ☐
Have all your children completed their education? Yes ☐ No ☐
Are any of your children receiving SSI or another form of government entitlement? Yes ☐ No ☐
Do any of your family members have problem with Aids? Yes ☐ No ☐
Drug Addiction? Yes ☐ No ☐
Alcoholism? Yes ☐ No ☐
Spendthrift? Yes ☐ No ☐
Marital Problems? Yes ☐ No ☐
Do any of your children live with you? Yes ☐ No ☐
Does a sibling live with you? Yes ☐ No ☐

D. VETERANS BENEFIT INFORMATION (if applicable)

Is the Veteran currently receiving benefits from the VA? □ Yes □ No

If Yes, type of benefit:

□ Service-connected disability compensation Percentage_____

□ Non-service connected disability pension

□ Special Monthly Pension/Aid and Attendance

□ Housebound status

□ Enrolled in VA's Healthcare System

□ Currently have a claim pending before Veterans Administration

VA file number ______________________

Monthly benefit amount $_____________________ Date benefits began _______________________

E. HEALTH INSURANCE INFORMATION (Please check all that apply)

Husband

☐ Medicare Part A/B Premium $______________________
☐ Medicare Part D (Prescription Drug) Premium $_________________
☐ Tricare for Life
☐ Other Health Insurance
Name of Carrier: ______________________________________
Subscriber/Policy Number: ______________________________
Type of Coverage: _____________________________________

Name of Carrier: ______________________________________
Subscriber/Policy Number: ______________________________
Type of Coverage: _____________________________________

Wife

☐ Medicare Part A/B Premium $______________________
☐ Medicare Part D (Prescription Drug) Premium $_________________
☐ Tricare for Life
☐ Other Health Insurance
Name of Carrier: ______________________________________
Subscriber/Policy Number: ______________________________
Type of Coverage: _____________________________________

Name of Carrier: ______________________________________
Subscriber/Policy Number: ______________________________
Type of Coverage: _____________________________________

F. MONTHLY INCOME (Please provide the **Gross** Monthly Benefit Amount)

	Husband's	Wife's
Social Security Benefits	$____________	$____________
Pension/Retirement Benefits (Gross)	$____________	$____________
VA Disability Benefit	$____________	$____________
Investment Income	$____________	$____________
Other Income		
Source: ___________	$____________	$____________
Source: ___________	$____________	$____________
Source: ___________	$____________	$____________
TOTAL GROSS MONTHLY INCOME	$____________	$____________

G. MONTHLY SHELTER EXPENSES - (Please divide annual expenses by 12 and quarterly expenses by 4)

Rent/Mortgage	$_____________
Real Estate Taxes	$_____________
Water	$_____________
Sewer	$_____________
Utilities	$_____________

(Heat, Electricity, Phone)
(1/12th of last 12 months)

Homeowner's insurance premium $______________
Condominium fees $______________

Total Monthly Housing Expenses $______________

H. MONTHLY NON-SHELTER LIVING EXPENSES

Food $______________
Medical $______________
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. GIFTS - Gifts include, but are not limited to: cash/checks for birthday and Christmas presents, donations to your church, tuition payments for your grandchildren and charitable contributions.

Have you ever filed a Federal Gift tax return? Yes ☐ No ☐

Please check the appropriate box:

☐ We have not made gifts exceeding more than $1,000 in any one of the previous 5 years.

☐ We have made gifts exceeding $1,000 per year in the previous 5 years and all gifts are listed below (please use additional sheets of paper if you need more space):

Date _______________ Amount _________________ Recipient_______________________
Date _______________ Amount _________________ Recipient_______________________
Date _______________ Amount _________________ Recipient_______________________
Date _______________ Amount _________________ Recipient_______________________
Date _______________ Amount _________________ Recipient_______________________

J. <u>ASSETS/LIABILITIES</u> - Please insert the value of each asset/liability in the appropriate space.

Assets/Liabilities	**Husband**	**Wife**	**Joint**	**Liability**
Residence (assessed value)	$	$	$	$
Other Real Estate (assessed value) Other Real Estate (assessed value)	$ $	$ $	$ $	$ $
Automobile	$	$	$	$
Additional Automobile	$	$	$	$
Bank Accounts (Checking, Savings, CD's, Money Markets): Account# Account# Account#	$	$	$	$
Investments Brokerage Accounts, Stocks, Bonds, IRA's, Retirement Accounts, 401k): Account# Account# Account#	$	$	$	$
Stocks/Bonds not held by Broker	$	$	$	$
Life Insurance (Cash Value/Face Value) Company Name/Policy #	$	$	$	$
Nursing Home Deposit	$	$	$	$
Other Assets:	$	$	$	$
Total Values	$	$	$	$

K. ALL INFORMATION YOU PROVIDE TO US WILL BE KEPT CONFIDENTIAL AND USED FOR LONG-TERM CARE PLANNING PURPOSES ONLY.

Please bring copies of the following documents if you have them. If you do not have a copier, bring the originals and we will copy them for you.

Wills	Trusts
Powers of Attorney	Advance Medical Directives
Premarital or Marital Agreements	

Please also bring the following financial information if it applies to you:

Current bank statements including CD's	Deeds to all of your real property
Current real estate tax assessments	Notes or mortgages receivable to you
Investment, Brokerage, or Mutual Fund statements	Savings Bonds, Stock Certificates
Insurance & Annuity contracts and annuity statements	Pre-Need Funeral/Burial Contracts/Deeds
Retirement Accounts, IRA, or 401K statements	Titles and Registrations to all of your Motor Vehicles

The copies we have requested will help us understand how the assets are titled and how they may affect your plan.

L. <u>CERTIFICATION</u>

The undersigned hereby represents to Oast & Hook, 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.

______________ ______________________________________

Date Signature of Client or Client Representative