Long-term Care Planning Questionnaire (Single)

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--CLIENT

Full Name ____

Address ____

City ________________________ State __________ Zip __________

Telephone No.________________ Cell No. _______________________

Birth Date_______________ Place of Birth _____________________

Social Security No. __________________ Last Grade Completed _______________

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

If Veteran, dates of service ______________________

Marital Status: ☐ Widowed ☐ Divorced ☐ Never Married

If widowed, your spouse's date of death _____________

Was your former spouse a 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:	

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 ☐
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. <u>HEALTH INSURANCE INFORMATION</u> (Please check all that apply)

☐ 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: ____

☐ Dental Insurance

Name of Carrier: ____

Subscriber/Policy Number: ________________________________

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

Social Security Benefits	$____________________
Pension/Retirement Benefits	$____________________
Veterans Disability Income	$____________________
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:

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

☐ I 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. **ASSETS/LIABILITIES** - Please insert the value of each asset/liability in the appropriate space.

Assets/Liabilities	**Asset Total**	**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 - Company Name/Policy #	$ Face Value	$ Cash Value
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. These documents will help us understand how the assets are titled and how they may affect your plan.

Wills
Trusts
Powers of Attorney
Advance Medical Directives

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

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

L. CERTIFICATION

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