



NAWROCKI CENTER

For Elder & Family Law, PLLC

10299 Grand River, Suite N, Brighton, MI 48116
Tel 810-229-0220 • 810-632-1050
Toll Free 866-923-5337 • Fax 810-229-0696
www.nawrockilaw.com

LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan and protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long-Term Care. Whether you are new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

.....
DATE COMPLETED: _____

Name of person completing the form: _____

Are you a current client?

Yes _____ No _____

If you are completing this form for someone other than yourself and/or your spouse:

Address of person completing this form: _____

Relationship to person(s) described below: _____

SECTION 1. PERSONAL INFORMATION

(If the individual needing long-term care is single or widowed, complete only appropriate sections)

	<u>Husband (or Single Male)</u>	<u>Wife (or Single Female)</u>
Full Name:	_____	_____
Address:	_____ _____	_____ _____
Home Telephone:	(____)_____	(____)_____
Business Telephone:	(____)_____	(____)_____
Date of Birth:	_____	_____
Former/Maiden Name(s):	_____	_____
U.S. Citizen:	Yes_____ No_____	Yes_____ No_____
Social Security Number:	_____	_____
Military Service:	_____	_____
If deceased, date of death:	_____	_____

SECTION 2. MARITAL INFORMATION

Date of marriage: _____

Place of marriage (City, State, Country): _____

Prior Marriage(s): Husband/Single Male

<u>Name of Former Spouse</u>	<u>Date of Marriage</u>	<u>Place of Marriage</u>	<u>Yr. Terminated</u>
_____	_____	_____	_____
_____	_____	_____	_____

Prior Marriage(s): Wife/Single Female

<u>Name of Former Spouse</u>	<u>Date of Marriage</u>	<u>Place of Marriage</u>	<u>Yr. Terminated</u>
_____	_____	_____	_____
_____	_____	_____	_____

If a former spouse is still alive, describe the relationship with the former spouse:

SECTION 3. KEY FAMILY INFORMATION

Children (living and deceased). Indicate if adopted, and give the date adopted and the court granting adoption order. (Indicate if deceased by putting "D" and give date of death next to name). Please indicate whether any deceased child left any surviving children.

A. Children of present marriage: Husband/Single Male

<u>Name(s)</u>	<u>Address(es)</u>	<u>Phone No.(s)</u>	<u>Date of Birth</u>	<u>SS#</u>
1. _____	_____	_____	_____	_____
	_____	_____		
2. _____	_____	_____	_____	_____
	_____	_____		
3. _____	_____	_____	_____	_____
	_____	_____		
4. _____	_____	_____	_____	_____
	_____	_____		

B. Children of present marriage: Wife/Single Female

<u>Name(s)</u>	<u>Address(es)</u>	<u>Phone No.(s)</u>	<u>Date of Birth</u>	<u>SS#</u>
1. _____	_____	_____	_____	_____
	_____	_____		
2. _____	_____	_____	_____	_____
	_____	_____		
3. _____	_____	_____	_____	_____
	_____	_____		
4. _____	_____	_____	_____	_____
	_____	_____		

C. Children of prior marriage: Husband/Single Male

<u>Name(s)</u>	<u>Address(es)</u>	<u>Phone No.(s)</u>	<u>Date of Birth</u>	<u>SS#</u>
1. _____	_____	_____	_____	_____
	_____	_____		
2. _____	_____	_____	_____	_____
	_____	_____		
3. _____	_____	_____	_____	_____
	_____	_____		
4. _____	_____	_____	_____	_____
	_____	_____		

D. Children of prior marriage: Wife/Single Female

<u>Name(s)</u>	<u>Address(es)</u>	<u>Phone No.(s)</u>	<u>Date of Birth</u>	<u>SS#</u>
1. _____	_____	_____	_____	_____
	_____	_____		
2. _____	_____	_____	_____	_____
	_____	_____		
3. _____	_____	_____	_____	_____
	_____	_____		
4. _____	_____	_____	_____	_____
	_____	_____		

E. Do any children have “special needs?” (Explain; use back of sheet, if necessary). For example, think about their health and general financial status, including needs and abilities.

SECTION 4. HEALTH RELATED PROBLEMS

Husband: _____

Wife: _____

SECTION 5. CAPACITY

Are there any known problems with the individual's memory or understanding?

Husband (or Single Male): Yes _____ No _____
Wife (or Single Female): Yes _____ No _____

If you answered yes, please describe the nature of the problem: _____

Is the individual able to sign his or her name? Husband (or Single Male): Yes ___ No ___
Wife (or Single Female): Yes ___ No ___

Able to speak? Husband (or Single Male): Yes ___ No ___
Wife (or Single Female): Yes ___ No ___

Able to recognize family members and acquaintances? Husband (or Single Male): Yes ___ No ___
Wife (or Single Female): Yes ___ No ___

Cognizant of his or her property and personal possessions? Husband (or Single Male): Yes ___ No ___
Wife (or Single Female): Yes ___ No ___

Able to travel outside his or her current place of residence? Husband (or Single Male): Yes ___ No ___
Wife (or Single Female): Yes ___ No ___

SECTION 6. PHYSICIAN'S INFORMATION

(Please list the name and address of your primary physician)

Husband (or Single Male)

Wife (or Single Female)

Physician's name: _____

Specialty: _____

Address: _____

Business Telephone: (____) _____ (____) _____

SECTION 7. RESIDENCE – OWNED

(If rented, skip to Section 8)

A. Owner(s): _____

B. How is title held? _____

***PLEASE PROVIDE US WITH A COPY OF THE DEED AND MOST RECENT TAX BILL**

C. Fair Market Value? \$ _____

D. Outstanding Mortgage (listed amount): \$ _____

If so, is it a Reverse Annuity Mortgage (RAM)? Yes _____ No _____

Basic terms:

E. Single family residence? Yes _____ No _____

F. If the property is a multi-family unit, please provide the following:

1. Number of units: _____

2. Currently being rented? Yes _____ No _____

3. Are tenants under lease? Yes _____ No _____

G. If the property was purchased, please provide the following:

1. Date of purchase: _____
2. Purchase price: \$ _____

H. If the property was inherited, please provide the following:

1. Month/year of inheritance: _____
2. Value on date of inheritance \$ _____
(if available)

I. If improvements have been made to the property, please detail the value and nature of the improvements:

J. If at least one occupant of the residence is a child of the individual needing long-term care, has that child lived in the residence for at least two (2) years?

Yes _____ No _____

1. Has the child provided personal care to the parent(s) that might have delayed the need for long-term care for the parent(s)? Yes _____ No _____

2. If yes, please describe the nature and duration of the care provided:

L. Do the individual(s) needing care have any living children who are disabled?

Yes _____ No _____

If yes, please describe the nature of the disability: _____

M. If the owner has a brother or sister, has that brother or sister lived in the house for at least one (1) year?

Yes _____ No _____

If yes, does the sibling still reside in the home? Yes _____ No _____

SECTION 12. ASSETS/RESOURCES
(You may attach a copy of a portfolio instead)

Cash, CD's and Bank Balances:

Name of Bank and Account Number	Type of Account	How is Title Held?	Current Value
_____ # _____	_____	_____	\$ _____
_____ # _____	_____	_____	\$ _____
_____ # _____	_____	_____	\$ _____
_____ # _____	_____	_____	\$ _____
_____ # _____	_____	_____	\$ _____

Securities (Bonds, Marketable Securities, etc.)

Company or Bond Type	# of Shares/ Bond Cert.s	How is Title Held?	Cost	Current Value
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

IRA, 401(k), Keogh, and/or Other Retirement Accounts:

Institution Where Held/Acct. No.	Owner	Beneficiary	Date Established	Current Value
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____

Life and Accident Insurance & Annuities:

Company, Policy Type and Policy Number	Owner	Beneficiary	Death Value	Current Cash Value
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____
_____ # _____	_____	_____	_____	\$ _____

Real Estate:

Description/Location	How is Title Held?	Cost/Basis	Outstanding Mortgages?	Current Market Value
_____	_____	\$ _____	\$ _____	\$ _____

_____	_____	\$ _____	\$ _____	\$ _____

_____	_____	\$ _____	\$ _____	\$ _____

PLEASE PROVIDE US WITH COPIES OF DEEDS AND MOST RECENT TAX BILLS FOR EACH LISTED PARCEL OF REAL PROPERTY.

Personal Property:

	How is Title Held?	Current Value
Home Furnishings:	_____ (n/a) _____	\$ _____
Automobile(s) (list separately):		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
Other vehicle(s) (list separately):		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
For Items of Special Value (Antiques, jewelry, etc.), Include Description:		
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Business Interests:

If the individual(s) needing long-term care has any current business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.) of the business. Please bring a copy of any agreements, financial statements, etc.

Rights or Interests in Trusts, Estates, or Prospective Inheritance:

Briefly describe or give the name of the Trust in which the individual(s) needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

Miscellaneous:

If either (or both) individual(s) needing long-term care has any property interests not described above, please explain:

SECTION 13. EXEMPT RESOURCES

Under the Medicaid rules, certain items are “exempt” from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the individual needing care has the listed items:

Burial plot: (please provide a copy of deed)	Husband (or Single Male):	Yes ____	No ____
	Wife (or Single Female):	Yes ____	No ____
Irrevocable burial fund contract: (please provide a copy)	Husband (or Single Male):	Yes ____	No ____
	Wife (or Single Female):	Yes ____	No ____

SECTION 14. RESPONSIBLE PERSONS

Who now has “assistance” responsibilities (i.e., are any family members or other individuals providing custodial or other types of care to the individual needing assistance)? Please list name, phone number, and relationship to the person receiving the care:

For Husband (or Single Male): _____

For Wife (or Single Female): _____

SECTION 15. UNAVAILABLE CHILD(REN)

If the individual needing care has children, and any child(ren) are not to be relied upon for any reason to help with management or other needs of parents(s), please list the name of such child(ren) and provide a short explanation why you believe such is the case:

SECTION 16. COST OF LIVING (ESTIMATED) PER MONTH

	Husband/Male	Wife/Female	Both
Housing			
If home is owned, estimate total cost of mortgage, taxes, utilities, phone, etc.* (monthly)	\$ _____	\$ _____	\$ _____
If rented, estimate monthly rental/lease expense (including any maintenance fees)	\$ _____	\$ _____	\$ _____
Insurance Premiums (monthly)			
Health	\$ _____	\$ _____	\$ _____
Long-term care	\$ _____	\$ _____	\$ _____
Life	\$ _____	\$ _____	\$ _____

Food	\$ _____	\$ _____	\$ _____
Medical	\$ _____	\$ _____	\$ _____
Clothing	\$ _____	\$ _____	\$ _____
Transportation (inc. gas & insurance)	\$ _____	\$ _____	\$ _____
Home Maintenance	\$ _____	\$ _____	\$ _____
Federal & State Income Taxes	\$ _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____	\$ _____
TOTALS	\$ _____	\$ _____	\$ _____

*Is the senior citizen real property tax exemption being used? Yes _____ No _____
 *Is the veterans real property tax exemption being used? Yes _____ No _____

SECTION 17. HEALTH AND LTC INSURANCE

Use back of form if necessary

If either and/or both individual(s) have private health or long-term care insurance, or are paying for a Medicare supplement policy, please provide the following information:

Name of Insurance and Policy Number	Type of Policy	Monthly Premium	If Long-Term Care Ins, daily benefit
_____	_____	\$ _____	\$ _____
# _____			
_____	_____	\$ _____	\$ _____
# _____			
_____	_____	\$ _____	\$ _____
# _____			
_____	_____	\$ _____	\$ _____
# _____			

SECTION 18. PLANNING AND OTHER DOCUMENTS

(Please provide us with a copy of each document)

				<u>Date Executed</u>	
				Husband/Male	Wife/Female
Wills	Have originals?	Y _____	N _____	_____	_____
	Copies?	Y _____	N _____	_____	_____
Durable	Have originals?	Y _____	N _____	_____	_____

Power of Attorney	Copies?	Y_____ N_____	_____	_____
Health Care Proxy	Have originals? Copies?	Y_____ N_____ Y_____ N_____	_____	_____
Living Will	Have originals? Copies?	Y_____ N_____ Y_____ N_____	_____	_____
Trusts (Revocable)	Have originals? Copies?	Y_____ N_____ Y_____ N_____	_____	_____
Trusts (Other)	Have originals? Copies?	Y_____ N_____ Y_____ N_____	_____	_____

SECTION 19. TRANSFERS WITHIN 60 MONTHS

Has the individual(s) transferred property to someone other than his or her spouse within the past five years?

Husband (or Single Male): If so, please provide the following information:

<u>Recipient</u>	<u>Amount</u>	<u>Date</u>
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Gift tax returns filed on any gifts? (*Please provide copies, if available*) Yes _____ No _____

Wife (or Single Female): If so, please provide the following information:

<u>Recipient</u>	<u>Amount</u>	<u>Date</u>
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

Gift tax returns filed? (*Please provide copies, if available*) Yes _____ No _____

