NAWROCKI CENTER
For Elder Law, Special Needs
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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)

	Husband (or Single Male)	Wife (or Single Female)
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

Name of Former Spouse	*Date of Marriage*	*Place of Marriage*	*Yr. Terminated*

Prior Marriage(s): Wife/Single Female

Name of Former Spouse *Date of Marriage* *Place of Marriage* *Yr. Terminated*

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

1.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

2.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

3.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

4.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

B. Children of present marriage: Wife/Single Female

1.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

2.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

3.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

4.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

C. Children of prior marriage: Husband/Single Male

1.

Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

2.

Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

3.

Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

4.

Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

D. Children of prior marriage: Wife/Single Female

1.

Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

2.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

3.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

4.
Name: _____Date of Birth_____

Address: _____City: _____State: _____Zip: _____

Home phone: _____ Cell phone: _____

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 8. RESIDENCE – RENTED

Monthly cost: $ _____

Type of rental:
Single Family _____ Apartment_____
Residential Care _____ Life Care _____
Senior Housing _____

Is there a rental or lease agreement? Yes _____ No _____

Is the rent being subsidized? Yes _____ No _____

If so, by whom and for how much? _____

$_____

SECTION 9. LONG-TERM CARE (LTC)

Is the individual(s) currently receiving long-term care?
Husband (or Single Male): Yes _____ No _____
Wife (or Single Female): Yes _____ No _____

If so, what was the date of entry into the nursing home or facility, or the date the home care was started?

Husband (or Single Male): _____ Wife (or Single Female): _____

Name of the LTC facility/provider: _____

Address: _____

_____

Telephone Number: (____)_____

Administrator (or other contact): _____

Is the facility Medicaid-certified? Yes _____ No _____

Was the stay in the facility or the home care immediately preceded by a hospital stay?

Yes _____ No_____

How long was the hospital stay? _____

SECTION 10. HOSPITAL

Is either individual currently in a hospital?

Husband (or Single Male): Yes ____ No____
Wife (or Single Female): Yes ____ No____

Name/location of the Hospital: _____

_____

_____

Please list the current duration of the hospital stay, and a brief description of the medical problem: _____

_____

Is placement in a LTC facility expected?

Husband (or Single Male): Yes ____ No ____

Wife (or Single Female): Yes ____ No ____

If placement is expected, is it likely that he or she will return home?

Husband (or Single Male): Yes ____ No ____

Wife (or Single Female): Yes ____ No ____

SECTION 11. INCOME

In completing the following section, use the "name on the check" rule, i.e., the individual(s) whose name appears on the payment vehicle is the "owner" of the income:

Fixed Monthly	Husband/Single Male	Wife/Single Female	Joint
Social Security	$_____	$_____	$_____
R.R. Retirement	$_____	$_____	$_____
Pension	$_____	$_____	$_____
Veterans Disability	$_____	$_____	$_____
Annuity Income	$_____	$_____	$_____
Other (describe) _____			
$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____

Non-Fixed Monthly

Interest	$_____	$_____	$_____
Dividends	$_____	$_____	$_____
Other (describe)	$_____	$_____	$_____

$_____ $_____ $_____ $_____

$_____ $_____ $_____ $_____

TOTAL INCOME: $_____ $_____ $_____

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.)

1. Company or Bond Type _____

Number of Shares/ how is Bond Certificate Title held? _____

Cost _____ Current Value: _____

2. Company or Bond Type _____

Number of Shares/ how is Bond Certificate Title held? _____

Cost _____ Current Value: _____

3. Company or Bond Type _____

Number of Shares/ how is Bond Certificate Title held? _____

Cost _____ Current Value: _____

4. Company or Bond Type _____

Number of Shares/ how is Bond Certificate Title held? _____

Cost _____ Current Value: _____

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

1. Institution Where Held:

_____ Account #_____

Owner: _____ Beneficiary: _____

Date Established: _____ Current Value: $_____

2. Institution Where Held:

_____ Account #_____

Owner: _____ Beneficiary: _____

Date Established: _____ Current Value: $_____

3. Institution Where Held:

_____ Account #_____

Owner: _____ Beneficiary: _____

Date Established: _____ Current Value: $_____

4. Institution Where Held:

_____ Account #_____

Owner: _____ Beneficiary: _____

Date Established: _____ Current Value: $_____

5. Institution Where Held:

_____ Account #_____

Owner: _____ Beneficiary: _____

Date Established: _____ Current Value: $_____

Life and Accident Insurance & Annuities:

1. Company
_____ Policy Type: #_____

Owner: _____ Beneficiary: _____

Death Value: _____ Current Value: $_____

2. Company
_____ Policy Type: #_____

Owner: _____ Beneficiary: _____

Death Value: _____ Current Value: $_____

3. Company
_____ Policy Type: #_____

Owner: _____ Beneficiary: _____

Death Value: _____ Current Value: $_____

4. Company
_____ Policy Type: #_____

Owner: _____ Beneficiary: _____

Death Value: _____ Current Value: $_____

5. Company
_____ Policy Type: #_____

Owner: _____ Beneficiary: _____

Death Value: _____ Current Value: $_____

Real Estate:

1. Description/Location: _____

How is Title Held? _____ Cost/Basis _____

Outstanding Mortgage(s)? _____

Current Market Value $_____ Mortgages Value $_____

2. Description/Location: _____

How is Title Held? _____ Cost/Basis _____

Outstanding Mortgage(s)? _____

Current Market Value $_____ Mortgages Value $_____

3. Description/Location: _____

How is Title Held? _____ Cost/Basis _____

Outstanding Mortgage(s)? _____

Current Market Value $_____ Mortgages 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: Husband (or Single Male): Yes ____ No _____
(please provide a copy of deed) 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: $_____

Name of Insurance and Policy Number: _____

_____ Type of Policy: _____

Monthly Premium: $_____ If Long-term Care, Ins. Daily benefit: $_____

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)

			Date Executed	
			Husband/Male	Wife/Female
Wills?				
Have originals?	Y_____	N_____	_____	_____
Copies?	Y_____	N_____	_____	_____
Durable Powers of Attorney?				
Have originals?	Y_____	N_____	_____	_____
Copies?	Y_____	N_____	_____	_____

Health Care Proxy?

Have originals?	Y_____	N_____	_____	_____
Copies?	Y_____	N_____	_____	_____

Living Will

Have originals?	Y_____	N_____	_____	_____
Copies?	Y_____	N_____	_____	_____

Trusts (Revocable)

Have originals?	Y_____	N_____	_____	_____
Copies?	Y_____	N_____	_____	_____

Trusts

Have originals?	Y_____	N_____	_____	_____
Copies?	Y_____	N_____	_____	_____

(Other)

Have originals?	Y_____	N_____	_____	_____
Copies?	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:

Recipient	Amount	Date
_____	$_____	
_____	$_____	
_____	$_____	

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:

Recipient	Amount	Date
_____	$_____	
_____	$_____	
_____	$_____	

Gift tax returns filed? ***(Please provide copies, if available)***

Yes _____ No_____

SECTION 20. TRANSFERS TO OR FROM TRUSTS

Has the individual(s) transferred property into a Trust, or directed that property be transferred from a Trust (usually a revocable Trust) within the past sixty (60) months?

Husband (or Single Male): Yes _____ No_____
Wife (or Single Female): Yes _____ No_____

If so, please provide the following information:

Name of Trust	Amount	Date
_____	$_____	
_____	$_____	
_____	$_____	

SECTION 21. GOALS OF CLIENT

Statement of goals: