

## 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

	<u>Husband</u>	<u>Wife</u>
Full Name	_____	_____
Address	_____	_____
City	_____	_____
State	_____	_____
Zip	_____	_____
Telephone No.	_____	_____
Cell No.	_____	_____
Birth Date	_____	_____
Place of Birth	_____	_____
Last Grade Completed	_____	_____
Social Security No.	_____	_____
Date of Marriage	_____	_____
U.S. Citizen?	Yes <input type="checkbox"/> No <input type="checkbox"/>	U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>
Veteran?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Veteran? Yes <input type="checkbox"/> No <input type="checkbox"/>
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)

	<u>Husband's</u>	<u>Wife's</u>
Social Security Benefits	\$ _____	\$ _____
Pension/Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Investment Income	\$ _____	\$ _____
Other Income		
Source: _____	\$ _____	\$ _____
Source: _____	\$ _____	\$ _____
Source: _____	\$ _____	\$ _____
<b>TOTAL GROSS MONTHLY INCOME</b>	<b>\$ _____</b>	<b>\$ _____</b>

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

<b>Assets/Liabilities</b>	<b>Husband</b>	<b>Wife</b>	<b>Joint</b>	<b>Liability</b>
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  
Powers of Attorney

Trusts  
Advance Medical Directives

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. 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