LONG-TERM CARE PLANNING QUESTIONNAIRE
(SINGLE)

Date________________________________ File No.________________________________
Home Phone No.______________________ Business Phone No.______________________
Cell Phone No.______________________ Fax No.________________________________
E-Mail Address____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to your appointment.

A. CLIENT DATA

Full Name____
(print name as shown on your checks)

Street Address____

City____ State___________ Zip___________

Birth Date_____________________________ Social Security No.___________________

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

If widowed, please list name of spouse and date of death ______________________________

Was your former spouse a Veteran? ☐ Yes ☐ No

If you or your former spouse is or was a Veteran, are you receiving Tricare? ☐ Yes ☐ No

B. MEDICAL DATA

1. HEALTH

Diagnosis____

If you are already in a nursing home:

Name of Nursing Home____

Date Entered____

2. PHYSICIAN

Full Name of Primary Physician ____

Street Address ____

City ______________________________ State __________ Zip __________

3. PHARMACEUTICAL PLANS

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior GOLD? ☐ Yes ☐ No

If you are a Pennsylvania resident, are you currently receiving benefits under PACE? ☐ Yes ☐ No

If you re a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? ☐ Yes ☐ No

C. MONTHLY INCOME

Net Social Security Benefits $__________________

Medicare Part B Deduction $__________________

Co-pay for Medicare Part D (if applicable) $__________________

Retirement Benefits (Gross) $__________________

Veterans Disability Income $__________________

Annuity Income $__________________

Rental Income $__________________

TOTAL MONTHLY INCOME $__________________

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Do not include interest and dividend income on this form.

D. GIFTS

Have you made any gifts within the last five years to an individual or to a trust? ☐ Yes ☐ No

If yes, list below:

Recipient________________________________ Date ____________ Amount __________

Recipient________________________________ Date ____________ Amount __________

Recipient________________________________ Date ____________ Amount __________

Recipient________________________________ Date ____________ Amount __________

Recipient________________________________ Date ____________ Amount __________

Have you ever filed a Federal Gift Tax Return? ☐ Yes ☐ No

If yes, please state details ____

____

____

E. CHILDREN (if applicable, include adult and minor children)

Name of Child____ Gender: ☐ Male ☐ Female

Street Address____

City________________________________ State_________________ Zip ________________

Home Phone Number_________________ Work Phone Number ______________________

Date of Birth_______________________ Social Security Number ____________________

E-mail Address____

Relationship: ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Child born out of wedlock

Name of Child________________________________ Gender: ☐ Male ☐ Female

Street Address____

City_________________________ State______________ Zip ______________

Home Phone Number______________ Work Phone Number______________________

Date of Birth___________________ Social Security Number_____________________

E-mail Address____

Relationship: ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Child born out of wedlock

Name of Child________________________________ Gender: ☐ Male ☐ Female

Street Address____

City_________________________ State______________ Zip ______________

Home Phone Number______________ Work Phone Number______________________

Date of Birth___________________ Social Security Number_____________________

E-mail Address____

Relationship: ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Child born out of wedlock

Name of Child________________________________ Gender: ☐ Male ☐ Female

Street Address____

City_________________________ State______________ Zip ______________

Home Phone Number______________ Work Phone Number______________________

Date of Birth___________________ Social Security Number_____________________

E-mail Address____

Relationship: ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Child born out of wedlock

Name of Child________________________________ Gender: ☐ Male ☐ Female

Street Address____

City________________________ State______________ Zip ______________

Home Phone Number______________ Work Phone Number______________________

Date of Birth__________________ Social Security Number_____________________

E-mail Address____

Relationship: ☐ Natural child ☐ Adopted ☐ Stepchild ☐ Child born out of wedlock

Are all of 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 other form of government entitlement? ☐ Yes ☐ No

If yes: How much is the child's monthly payment? $______________________________

Child is receiving ☐ Medicaid ☐ Medicare ☐ Veterans Disability Benefits

Do any of your family members have any problems with:

AIDS? ☐ Yes ☐ No
Drug Addiction? ☐ Yes ☐ No
Alcoholism? ☐ Yes ☐ No
Spendthrift? ☐ Yes ☐ No
Marital Difficulty? ☐ Yes ☐ No

Do any of your children live with you in your home? ☐ Yes ☐ No

If yes, name of child ____

Does a sibling live in your home with you? ☐ Yes ☐ No

If yes, name of sibling ____

Are you a contributor to a 529 Plan? ☐ Yes ☐ No

If yes, please attach a statement of the 529 account.

F. CONTACT INFORMATION

Name____

Street Address____

City______________________ State__________ Zip__________

Home Phone Number______________ Work Phone Number______________

Cell Number ______________ Fax Number______________

E-mail Address____

G. MISCELLANEOUS

Do you have any other legal issues which I should be aware of: ☐ Yes ☐ No

If yes, please explain ____

____

____

H. REFERRAL

By Whom Were You Referred To This Office?

Name____

Street Address____

City______________________ State__________ Zip__________

Home Phone Number______________ Work Phone Number______________

Cell Number ______________ E-mail Address______________

Referral is: ☐ Attorney ☐ Financial Planner

☐ Previous Client of Begley & Bookbinder ☐ Doctor

☐ Social Worker ☐ Other______________

Have you visited our Website at www.njelderlaw.com or www.begleylawyer.com? Yes ☐ No ☐

Do you have any ideas for improving our Website? If so, please discuss.

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I. **CERTIFICATION**

The undersigned hereby represents to Begley & Bookbinder, P.C., 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.

Signature of Client or Client Representative:

____

MEDICAID PLANNING -ADDITIONAL INFORMATION

Last Name of Client________________________________ **File No.**_________________

A. ASSETS/LIABILITIES

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING		
SAVINGS		
MONEY MARKET		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK#___________ LOT#___________ EQ. RATIO ______ REM. FCTR ________		
OTHER REAL ESTATE BLOCK#___________ LOT#___________ EQ. RATIO ______ REM. FCTR ________		
AUTOMOBILE(S)		
BROKERAGE/CAP ACCOUNTS		

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
TRADITIONAL IRA/RETIREMENT PLANS		
ROTH IRA		
NURSING HOME DEPOSIT		
PREPAID FUNERAL		
OTHER:		
OTHER:		
OTHER:		
TOTAL		

Residence Information

Purchase Price $____________________

Purchase Costs
(title & escrow fees, real estate agent commissions, etc.) + $____________________

Improvements + $____________________

Selling Costs
(title & escrow fees, real estate agent commissions, etc.) + $____________________

Accumulated Depreciation - $____________________

Cost Basis = $____________________

Have you owned the property for 2 of the last 5 years? ☐ Yes ☐ No

Have you occupied the property for 2 of the last 5 years? ☐ Yes ☐ No

Have you sold property within the last 2 years? ☐ Yes ☐ No

If yes:

What was the cost basis of the property? $____________________

What was the sales price? $____________________

Have you gifted property? ☐ Yes ☐ No

If yes:

Number of Donees ____________________

Amount of Credit Available ____________________

Other Real Property Information

Address of any real property other than personal residence:

(1)Street ____________________City ____________State________Zip ________

Tax Block #____________, Lot #____________ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $ ____________________

(2)Street ______________________________City ____________State________Zip ________

Tax Block #______________, Lot #______________ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $ ____________________

Name of Homeowner's Insurance Company ______________________________

Street Address ______________________________

City ______________________________ State__________ Zip __________

Phone No.______________________ Policy No. ______________________

B. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost $____________

Monthly Prescription Cost $____________

Monthly Incontinent Cost $____________

Monthly Medical Insurance Cost $____________

Monthly Other Cost $____________

Total Monthly Cost $____________

The nursing home is paid through ______________________________(month/year).

C. LIFE INSURANCE

Name of Insurance Company______________________ Policy # ______________

Street Address ______________________________

City______________________ State____________ Zip______________

Type of Policy______________ Owner______________________

Insured__________________ Beneficiary______________________

Death Benefit: $__________ Face Value: $__________ Cash Value: $ __________

Name of Insurance Company________________________________ Policy # ____________________________

Street Address____

City________________________________ State__________________ Zip______________________

Type of Policy_____________________ Owner____

Insured____________________________ Beneficiary____

Death Benefit: $__________ Face Value: $__________ Cash Value: $ ________________________

Name of Insurance Company________________________________ Policy # ____________________________

Street Address____

City________________________________ State__________________ Zip______________________

Type of Policy_____________________ Owner____

Insured____________________________ Beneficiary____

Death Benefit: $__________ Face Value: $__________ Cash Value: $ ________________________

Name of Insurance Company________________________________ Policy # ____________________________

Street Address____

City________________________________ State__________________ Zip______________________

Type of Policy_____________________ Owner____

Insured____________________________ Beneficiary____

Death Benefit: $__________ Face Value: $__________ Cash Value: $ ________________________

Name of Insurance Company________________________________ Policy # ____________________________

Street Address____

City________________________________ State__________________ Zip______________________

Type of Policy_____________________ Owner____

Insured____________________________ Beneficiary____

Death Benefit: $__________ Face Value: $__________ Cash Value: $ ________________________