LONG-TERM CARE WORKSHEET

Please complete this questionnaire as fully as possible in pencil. Accuracy to the last dollar is not necessary at this time, but the more exact your numbers are, the more precise I can be in answering any questions. Bring this questionnaire to the initial meeting along with the following documents:

Will(s) _____ Recent Tax Returns (last 2 years) _____

Trust(s) _____ Health Insurance Policies and Premiums _____

Deed(s) _____ Health Care Documents _____

Power of Attorney _____ Recent Brokerage Statements _____

Recent Bank Statements showing ownership and current values _____

PART I: PERSONAL INFORMATION

1. NAME Client _____

Spouse _____

2. ADDRESS

_____

_____

3. TELEPHONE

Home _____ Fax _____ email _____

Client's cell _____ Fax _____ email _____

4. SOCIAL SECURITY NUMBERS

Client _____ Spouse _____

5. PLACE AND DATE OF BIRTH

Client _____ Spouse _____

Date _____ Date _____

6. CITIZENSHIP

Client _____ Spouse _____

7. MILITARY SERVICE (Note: if you have discharge papers (DD-214), please have them available)

Client _____ Spouse _____

8. MARRIAGES

Client _____ Spouse _____

Date and Place _____ Date and Place _____

Divorced? (date and place) _____ Divorced? (date and place) _____

Deceased? (date and place) _____ Deceased? (date and place) _____

9. CURRENTLY IN A FACILITY? _____ Y _____ N

Facility _____ Date of Admission_____

_____ Phone number _____

_____ **Monthly Cost _____**

9. LIST FAMILY MEMBERS

Name Relationship D.O.B. Address; phone; email

_____

_____

_____

_____

_____

10. ADVISORS

Name Address Phone

A. Lawyer. _____

B. Accountant _____

C. Insurance Agent _____

D. Employer _____

E. Financial Advisor. _____

F. Physician _____

G. Others?. _____

11. HEALTH INSURANCE

A. Medicare Number Client_____

Spouse _____

Premium amount _____/month Payor (self; company etc.) _____

Part A? _____ Part B? _____

B. Private Insurance (Medigap): List Company, Number, Premium (quarterly)

Client_____

Spouse _____

Premium amount _____/month Payor (self, company etc.) _____

C. Medicare Part D (Rx) Coverage _____

Premium Amount_____/month Payment is: Deducted from Social Security _____

Paid by insured _____

D. Do you have Long Term Care Insurance? [] Yes [] No

If yes, list the name of the insured, the insurance company, and describe the benefits:

_____

_____

12. WHAT ARE YOUR GOALS FOR CONDUCTING THIS PLANNING

A._____

B._____

PART II: BUDGET

1. GROSS INCOME (<u>prior to any deductions</u>):	Client	Spouse	Marital/Joint (not previously listed)
A. Earned monthly income	_____	_____	_____
B. Monthly Social Security	_____	_____	_____
C. Monthly Pension Income	_____	_____	_____
D. Rental	_____	_____	_____
E. Bank Interest	_____	_____	_____
F. Annuities	_____	_____	_____
G. Other monthly income	_____	_____	_____
TOTAL MONTHLY INCOME	**$_____**	**$_____**	**$_____**

2. EXPENSES:

A. Monthly costs _____

1. Utilities _____
2. Medication _____
3. Medicare B _____
4. Medicare Part D _____
5. Supplemental Health Insurance _____
6. Automobile _____
7. Mortgage/rent/fee _____
8. Property Taxes _____
9. Life Insurance Premiums _____
10. Long Term Care Insurance _____
11. Home Health Aide _____

B. Miscellaneous costs _____

Approximate costs of cable, telephone, clothing, donations, subscriptions, etc.

TOTAL MONTHLY EXPENSES _____

PART III: ASSETS AND LIABILITIES

1. REAL ESTATE Please bring copies of all deeds and rental agreements

A. Residential

Address _____

Ownership _____

Mortgage _____ Present Value _____ Assessed _____

Purchased in (year) _____ Purchase Price _____ Improvements _____

B. Vacation

Address _____

Ownership _____

Mortgage _____ Present Value _____ Assessed _____

Purchased in (year) _____ Purchase Price _____ Improvements _____

C. Rental

Address _____

Ownership _____

Mortgage _____ Present Value _____ Assessed _____

Purchased in (year) _____ Purchase Price _____ Improvements _____

2. BANK ACCOUNTS

Bank	**Number**	**Type** (checking, savings, CDS)	**Ownership** (list joint owner(s))	**Amount**

TOTAL AMOUNT IN BANK ACCOUNTS _____

3. STOCKS AND MUTUAL FUNDS

# of Shares	**Company**	**Purchased for**	**Ownership**	**Current Value**

TOTAL STOCKS AND MUTUAL FUNDS _____

4. TREASURY BONDS, SAVINGS BONDS, AND T-BILLS

Issue Date	Maturity	Ownership	Value

TOTAL BONDS _____

5. ANNUITIES

Company	Policy #	Type (is it paying income now or deferred?)	Ownership	Present Value

TOTAL ANNUITIES _____

6. PENSIONS AND RETIREMENT ACCOUNTS

Owner	Company	Qualified?	Survivor Rights	Value

TOTAL PENSION AND RETIREMENT _____

7. BUSINESS INTERESTS

_____

_____

TOTAL BUSINESS INTERESTS _____

8. LIFE INSURANCE

Insured	Company	Policy #	Beneficiary	Face Amount	Premium

TOTAL LIFE INSURANCE _____

9. AUTOMOBILE(S):

	Description	Ownership	Value
a. Automobile			

b. Automobile			

TOTAL ASSETS _____

LIABILITIES

10. CREDIT CARDS _____

11. LOANS _____

12. MORTGAGES _____

13. OTHER _____

TOTAL LIABILITIES _____

NET WORTH _____

PART IV: TRANSFERS

TRANSFERS/GIFTING

In the last 60 months (5 years), have any assets belonging to the applicant or the spouse of the applicant been transferred to another person, has the applicant's name been removed from any asset (e.g. a joint account), or has the applicant made any gifts?

Yes _____ No _____

	Date of transfer	Amount/Asset	To whom/explanation (e.g. birthday gift, transfer, removed name)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Total Amount of Transfers _____