

# BRIEF LONG-TERM CARE PLANNING QUESTIONNAIRE

## GENERAL INFORMATION

### Disabled Person Information

<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>
<b>Nickname (if any)</b>		<b>Alias Name (if any)</b>
<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>SS#</b>	<b>Date of Birth</b>
<b>U.S. Citizen</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If No, specify citizenship</b>	<b>Veteran</b> [ ] Yes Years: _____ [ ] No
<b>Health</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Reasonably good <input type="checkbox"/> Poor <input type="checkbox"/> Serious Adverse Condition	<b>Legally blind</b> [ ] Yes [ ] No	<b>Disabled</b> [ ] Yes [ ] No
Describe any chronic health conditions:		
<b>Marital Status:</b> [ ] Married [ ] Divorced [ ] Widowed [ ] Never married	<b>Who else lives in the home with this person?</b>	

### Contact Information

<b>Address</b>		
<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Home Phone</b>	<b>Home Fax</b>	<b>Cell Phone</b>
<b>Personal email</b>		
<b>Business Phone</b>	<b>Business Fax</b>	<b>Business Cell Phone</b>
<b>Business email</b>		
<b>Other phone:</b>		

**ALL CHILDREN (whether in good graces or not!)**

Name & Address	Living	Gender	Date of Birth	Child of Both, Client Only or Spouse only	Legally Blind	Disabled	Receives SSI	Completed Education
	Y/N	M/F			Y/N	Y/N		
	Y/N	M/F			Y/N	Y/N		
	Y/N	M/F			Y/N	Y/N		
	Y/N	M/F			Y/N	Y/N		
	Y/N	M/F			Y/N	Y/N		
	Y/N	M/F			Y/N	Y/N		

**ASSETS AND LIABILITIES**

Personal Net Worth: \$ \_\_\_\_\_  
 Annual Income \$ \_\_\_\_\_

Does this person have interest in qualified pension plan(s)?  Yes  No

**FINANCIAL SUMMARY**

	Description	ASSETS Asset Value	LIABILITIES
<b>Cash/Liquid</b>	Savings		
	Checking		
	Money Market		
	Other		
<b>Real Estate</b>			
	Primary Residence		

	Secondary		
	Other		
<b>Personal Property</b>			
	Automobiles		
	Jewelry		
	Art or Other Collections		
	Boats		
	Other		
<b>Intangibles</b>			
	Bonds		
	Stock		
	Mutual Funds		
	Note & Mortgages Receivables		
	Future Inheritance		
	Interests in Trusts		
	Annuities		
	Other		
<b>Retirement Benefits</b>			
	IRAs		
	401K		
	Keough Plan		
	SEP		
	Other		
<b>Life Insurance</b>			
	Cash Value of all policies		
<b>Other Assets</b>			

**Please provide a list of all life insurance policies on each of your lives showing the face value, policy loans, the owner and beneficiary of each policy and supporting documents for all financial data listed above.**

Has Disabled person or spouse made gifts in the last five years?  Yes  No

### **EXISTING PLANNING**

Does person have a Power of Attorney?  Yes  No

Does person have a Health Care Power?  Yes  No

Does person have a HIPPA release?  Yes  No

Has a conservator or guardian ever been appointed for this person?  Yes  No

Does person have a Last Will and Testament or Trust?  Yes  No

Name of person completing questionnaire: \_\_\_\_\_ Date: \_\_\_\_\_