GRIFFITH ROBINSON, PLC
ATTORNEYS AT LAW

LONG-TERM CARE PLANNING QUESTIONNAIRE

This confidential questionnaire is designed to help us gather the information necessary to properly plan to 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. 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: _____

SECTION 1. NAME AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

Relationship to Client: _____

Client's Full Name: _____
(first) (middle) (last)

Spouse's Full Name: _____
(first) (middle) (last)

Home Address: _____

	Client	**Spouse**
Telephone Numbers:	_____ (home)	_____ (home)
	_____ (cell)	_____ (cell)
Date of Birth:	_____	_____
Former/Maiden Names:	_____	_____
US Citizen?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Social Security Number:	_____	_____
Dates of Military Service:	_____	_____

SECTION 2. MARITAL INFORMATION

A. Date of Marriage: _____

B. Has either spouse been previously married?_____

SECTION 3. CHILDREN

List all children. Copy and attach additional pages, if needed. Total number of children: _____

1. _____ _____
(name of child) (date of birth)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

[ ] Deceased _____ [ ] Yes [ ] No _____
(date of death) (child has surviving children?)

_____

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

2. _____ _____
(name of child) (date of birth)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

[ ] Deceased _____ [ ] Yes [ ] No _____
(date of death) (child has surviving children?)

_____

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

3. _____ _____
(name of child) (date of birth)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

[ ] Deceased _____ [ ] Yes [ ] No _____
(date of death) (child has surviving children?)

_____

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

4. _____ _____
(name of child) (date of birth)

Parent: [ ] Client [ ] Spouse [ ] Both

(current address) (phone number)

[ ] Deceased (date of death) [ ] Yes [ ] No (child has surviving children?)

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

(Use additional pages, if needed)

SECTION 4. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

B. Spouse

SECTION 5. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: [ ] Yes [ ] No

Spouse: [ ] Yes [ ] No

If yes, please explain:

SECTION 6. PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of your primary physician.

	Client	**Spouse**
Physician's Name:	_____	_____
Specialty:	_____	_____
Address:	_____	_____
	_____	_____
Business Phone:	_____	_____

SECTION 7. RESIDENCE -- OWNED

A. Owners: _____

B. How is title held? _____

PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL

C. Tax Assessed Value: $_____

D. Mortgage Balance: $_____

Is it a Reverse Mortgage or Home Equity line of credit? [ ] Yes [ ] No

Basic Mortgage Terms: _____

E. Single Family Residence? [ ] Yes [ ] No

F. If the property is rental property, please provide the following:

1. Address of rental property:_____
2. Currently being rented? [ ] Yes [ ] No
3. Are tenants under lease? [ ] Yes [ ] No

K. If at least one occupant of the residence is a child of the individual in need of long-term care, has that child lived in the residence for at least 2 years? [ ] Yes [ ] No

1. If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? [ ] Yes [ ] No

2. If so, please describe the nature and duration of the care provided:

_____

_____

_____

L. Does the person needing care have any living children who are disabled? [ ] Yes [ ] No

If yes, please describe the nature of the disability:

_____

_____

M. Does the owner have a sibling who has lived in the house for at least 1 year? [ ] Yes [ ] No

If yes, does the sibling still reside in the home? [ ] Yes [ ] No

SECTION 8. LONG-TERM CARE ("LTC")

A. Client

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

B. Spouse

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

SECTION 9. HOSPITAL

A. Client

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No If yes, was the client **admitted** to the hospital for 3 days or more? _____ No _____ Yes (please note that being under "observation status does not mean "admitted")

If so, likely to return home? [ ] Yes [ ] No

B. Spouse

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No If yes, was the client **admitted** to the hospital for 3 days or more? _____ No _____ Yes (please note that being under "observation status does not mean "admitted")

If so, likely to return home? [ ] Yes [ ] No

SECTION 10. INCOME

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment vehicle is the "owner" of the income.

A. FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Social Security:	$	$	$
2.	Military Retirement:	$	$	$
3.	Pension:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$

B. NON-FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Interest:	$	$	$
2.	Dividends:	$	$	$
3.	_____:	$	$	$

4. _____: $ _____ $ _____ $ _____

C. TOTALS (A thru B): $ _____ $ _____ $ _____

SECTION 11. ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)
(Please provide copies of statements and beneficiary designations, if applicable)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. (sample)	xxx-xxxx	Savings	$ xx,xxx.xx	Jointly w/ son
			$	
			$	
			$	
			$	

Safety Deposit Box ____ Yes _____No If yes, who has the key? _____

B. SECURITIES (Bonds, Marketable Securities, Mutual Funds, Annuities, etc.)
(Please provide copies of statements and beneficiary designations if applicable)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. (sample)	Common (or Preferred)	xx Shares	$ x,xxx.xx	$ x,xxx.xx	Sole owner
			$	$	
			$	$	
			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, 401k's, TSP's, etc.)
(Please provide copies of statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker (sample)	xxx-xxxx	Client	Spouse	Jan, 1970	$ xx,xxx.xx
					$
					$
					$

_____ _____ _____ _____ _____ $_____

_____ _____ _____ _____ _____ $_____

E. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$_____	_____
Cars, RVs, Boats, etc.:	$_____	_____
Jewels, Furs, etc.:	$_____	_____
_____: (other: collectibles, etc.)	$_____	_____

F. BUSINESS INTERESTS

If the person needing long-term care has any 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.). ***Please bring a copy of any operating or shareholder agreements, financial statements, etc***.

_____

_____

G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which the person 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***.

_____

_____

H. LIFE INSURANCE POLICIES AND ANNUITIES

TYPE: Term, whole life, split dollar, group life, annuity. **ADDITIONAL INFORMATION:** Insurance company, type, face amount (death benefit), cash surrender value, whose life is insured, who owns the policy, and the current beneficiaries.

_____

_____

_____

Total Death Value _____

MISCELLANEOUS

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each.

_____

_____

SECTION 12. 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 person needing care has the listed items.

	Client	**Spouse**
Burial plot:	[ ] Yes [ ] No	[ ] Yes [ ] No
Irrevocable burial fund contract:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 13. PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

A. Responsible for Client:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

B. Responsible for Spouse:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

SECTION 14. MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

	Client	**Spouse**	**Joint**
1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*:	$ _____	$ _____	$ _____
2. If home is rented, total rent, including maint. fees, if any:	$ _____	$ _____	$ _____

* Is the senior citizen real property tax exemption being used? [ ] Yes [ ] No
Is the veterans real property tax exemption being used? [ ] Yes [ ] No

B. INSURANCE PREMIUMS (PER MONTH)

		Client	Spouse	Joint
1.	Health insurance:	$	$	$
2.	Long-term care insurance:	$	$	$
3.	_____: (specify)	$	$	$
4.	_____: (specify)	$	$	$

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Non-covered medications:	$	$	$
2.	_____: (specify)	$	$	$
3.	_____: (specify)	$	$	$

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Food:	$	$	$
2.	Entertainment and travel:	$	$	$
3.	Support for children:	$	$	$
4.	_____: (specify)	$	$	$
5.	_____: (specify)	$	$	$
E.	**TOTALS (A thru D):**	**$**	**$**	**$**

Money You or Your Spouse Owe

TYPE: Mortgages, promissory notes, loans, etc. owed by you or your spouse

Name of Debtor	Date of Note	Maturity Date	Owed to	Current Balance
			Total	

SECTION 15. HEALTH AND LTC INSURANCE

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____

SECTION 16. PLANNING AND OTHER DOCUMENTS

****Please provide a copy of each document***.

	Client	**Spouse**
Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No	[ ] Yes [ ] No
Pour-Over Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Health Care Power of Attorney (or Proxy):	[ ] Yes [ ] No	[ ] Yes [ ] No
Living Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No	[ ] Yes [ ] No

(specify)

Contact name, phone number and address of attorney who drafted documents:

_____

Do you or your spouse have any pre-nuptial, post-nuptial, separation agreements, or divorce decrees?
____No _____Yes If yes, please describe: _____

**If yes, please provide a copy*.

SECTION 17. TRANSFERS or GIFTS WITHIN 60 MONTHS

Has the person needing care or his/her spouse transferred property or made gifts to someone other than his or her spouse within the past 60 months? Gifts may include paying tuition, rent, medical expenses, charitable donations, etc. If so, please provide the following information and **copies of gift tax returns, if available**:

A. Client

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____

B. Spouse

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____

SECTION 18. TRANSFERS TO OR FROM TRUSTS

Has the person needing care or his/her spouse transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

A. Client

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____

SECTION 19. CLIENT'S GOALS

What are your goals?

_____

_____

This information is true and accurate to the best of my knowledge and belief.

Client Signature_____ Date_____

Client Signature_____ Date_____