Weissler Law Group
Dedicated To Helping Families Prepare For Life Cycle Events,
Build and Protect Wealth

CONFIDENTIAL
LONG-TERM CARE PLANNING QUESTIONNAIRE

This 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. Whether you are a new or an established client, 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:	________________	________________
Military Service:	________________	________________
Date of Death:	________________	________________

SECTION 2. MARITAL INFORMATION

A. Date of Marriage: ________________________________

B. Place of Marriage: ________________________________

(city) (state or province) (country)

C. Client's Former Spouses:

1. ____________ (name of former spouse) ____________ (date of marriage) ____________ (place of marriage)

____________ (year terminated) [ ] Death [ ] Divorce (how terminated)

[ ] Yes [ ] No (still living?) ____________ (if still living, describe relationship)

2. ____________ (name of former spouse) ____________ (date of marriage) ____________ (place of marriage)

____________ (year terminated) [ ] Death [ ] Divorce (how terminated)

[ ] Yes [ ] No (still living?) ____________ (if still living, describe relationship)

3. ____________ (name of former spouse) ____________ (date of marriage) ____________ (place of marriage)

____________ (year terminated) [ ] Death [ ] Divorce (how terminated)

[ ] Yes [ ] No (still living?) ____________ (if still living, describe relationship)

D. Spouse's Former Spouses:

1. ____________ (name of former spouse) ____________ (date of marriage) ____________ (place of marriage)

____________ (year terminated) [ ] Death [ ] Divorce (how terminated)

[ ] Yes [ ] No (still living?) ____________ (if still living, describe relationship)

2. ______________________ ______________________ ______________________
(name of former spouse) (date of marriage) (place of marriage)

______________________ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No ______________________
(still living?) (if still living, describe relationship)

3. ______________________ ______________________ ______________________
(name of former spouse) (date of marriage) (place of marriage)

______________________ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No ______________________
(still living?) (if still living, describe relationship)

SECTION 3. CHILDREN

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

1. ______________________ ______________________ ______________________
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

______________________ ______________________
(current address) (phone number)

[ ] Adopted ______________________ ______________________
(date of adoption) (court granting adoption)

[ ] 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)

____
(Use additional pages, if needed)

2. ______________________ ______________________ ______________________
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

______________________ ______________________
(current address) (phone number)

[ ] Adopted ______________________ ______________________
(date of adoption) (court granting adoption)

[ ] 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)

____
(Use additional pages, if needed)

3. ______________________ ______________________ ______________________
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

(current address) (phone number)

[ ] Adopted ______________________ ______________________
(date of adoption) (court granting adoption)

[ ] 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)

(Use additional pages, if needed)

4. ______________________ ______________________ ______________________
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

(current address) (phone number)

[ ] Adopted ______________________ ______________________
(date of adoption) (court granting adoption)

[ ] 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)

(Use additional pages, if needed)

5. ______________________ ______________________ ______________________
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

(current address) (phone number)

[ ] Adopted ______________________ ______________________
(date of adoption) (court granting adoption)

[ ] 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)

(Use additional pages, if needed)

6. ______________________ ______________________ ______________________
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

____ ______________________
(current address) (phone number)

[ ] Adopted ______________________ ______________________
(date of adoption) (court granting adoption)

[ ] 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)

____
(Use additional pages, if needed)

SECTION 4. DISPOSITIVE PLANNING

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations. ***Please note that we expect that this will be completed during our first conference with you regarding estate planning. You may want to use this section as items to consider before our conference.***

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

A. First-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

____

____

B. Second-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

____

____

C. Third-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

____

____

D. Any specific disposition of your residence?

____

____

E. Any specific gifts of special articles, such as art or jewelry?

____

____

F. Any specific disposition of household and personal effects?

____

____

G. Other information you think is important to your estate planning:

____

____

SECTION 5. FIDUCIARIES

Please consider the who you want to handle your affairs when you cannot. ***We will discuss this section at our conference and will assist you with the completion.***

A. EXECUTORS (Co-Executors Act: [ ] Separately or [ ] Jointly)

1. ______________________________ ______________________
(name) (relationship)

______________________________ ______________________
(current address) (phone number)

2. ______________________________ ______________________
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

______________________________ ______________________
(current address) (phone number)

3. ______________________________ ______________________
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

______________________________ ______________________
(current address) (phone number)

4. ______________________________ ______________________
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

______________________________ ______________________
(current address) (phone number)

B. TRUSTEES (Co-Trustees Act: [ ] Separately or [ ] Jointly)

1. ______________________________ ______________________
(name) (relationship)

______________________________ ______________________
(current address) (phone number)

2. ______________________________ ______________________
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

______________________________ ______________________
(current address) (phone number)

3. ______________________________ ______________________
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

______________________________ ______________________
(current address) (phone number)

4. ______________________________ ______________________
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

______________________________ ______________________
(current address) (phone number)

C. GUARDIANS OF MINOR CHILDREN (Co-Guardians Act: [ ] Separately or [ ] Jointly)

1. ______________________________ ______________________
(name) (relationship)

______________________________ ______________________
(current address) (phone number)

2. ______________________________ ______________________
(name) (relationship)
[ ] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [ ] Yes [ ] No)
or [ ] Successor Guardian

______________________________ ______________________
(current address) (phone number)

3. ______________________________ ______________________
(name) (relationship)
[ ] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [ ] Yes [ ] No)
or [ ] Successor Guardian

______________________________ ______________________
(current address) (phone number)

4. ______________________________ ______________________
(name) (relationship)
[ ] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [ ] Yes [ ] No)
or [ ] Successor Guardian

______________________________ ______________________
(current address) (phone number)

D. AGENTS UNDER POWER OF ATTORNEY (Co-Agents Act: [ ] Separately or [ ] Jointly)

1. ______________________________ ______________________
(name) (relationship)

______________________________ ______________________
(current address) (phone number)

2. ______________________________ ______________________
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

______________________________ ______________________
(current address) (phone number)

3. ____ ____________________________
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

____ ____________________________
(current address) (phone number)

4. ____ ____________________________
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

____ ____________________________
(current address) (phone number)

E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY

1. ____ ____________________________
(name) (relationship)

____ ____________________________
(current address) (phone number)

2. ____ ____________________________
(name) (relationship)

____ ____________________________
(current address) (phone number)

3. ____ ____________________________
(name) (relationship)

____ ____________________________
(current address) (phone number)

4. ____ ____________________________
(name) (relationship)

____ ____________________________
(current address) (phone number)

SECTION 6. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

____

____

____

B. Spouse

____

____

____

SECTION 7. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: [ ] Yes [ ] No

Spouse: [ ] Yes [ ] No

If yes, please explain:

____

____

____

B. OTHER ISSUES

	Client	Spouse
Able to sign name?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to speak?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to recognize friends and family?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Cognizant of property and possessions?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to leave current residence?:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 8. 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 9. RESIDENCE -- OWNED

A. Owners: ______________________

B. How is title held? ______________________

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

C. Fair Market Value: $ ______________________

D. Mortgage Balance: $ ______________________

Is it a Reverse Annuity Mortgage (RAM)? [ ] Yes [ ] No

Basic Mortgage Terms: ______________________

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

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

1. Number of units: ______________________
2. Currently being rented? [ ] Yes [ ] No
3. Are tenants under lease? [ ] Yes [ ] No

G. If the property was purchased, please provide the following:

1. Date of Purchase: ______________________
2. Purchase Price: $ ______________________

H. If the property was inherited, please provide the following:

1. Month/Year Inherited: ______________________
2. Value when Inherited: $ ______________________

I. If improvements have been made to the property, please detail the value and nature of them:

____

____

____

J. Have the owners used the capital gains tax exclusion? [ ] 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 10. RESIDENCE -- RENTED

A. Monthly Rent: $ ____

B. Type of Rental: [ ] Single Family [ ] Apartment [ ] Residential Care
[ ] Life Care [ ] Senior Housing

C. Rental/Lease Agreement? [ ] Yes [ ] No

D. Is Rent Subsidized? [ ] Yes [ ] No

If so, by whom and amount? ____

SECTION 11. LONG-TERM CARE (LTC)

A. Client

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: ______________________________

Name of Facility/Provider: ______________________________

Address: ______________________________

____

Business Phone: ______________________________

Administrator or Contact: ______________________________

B. Spouse

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: ______________________________

Name of Facility/Provider: ______________________________

Address: ______________________________

____

Business Phone: ______________________________

Administrator or Contact: ______________________________

SECTION 12. 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 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 so, likely to return home? [ ] Yes [ ] No

SECTION 13. 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. R.R. Retirement:	$	$	$
3. Pension:	$	$	$
4. ____________:	$	$	$
5. ____________:	$	$	$
6. ____________:	$	$	$

B. NON-FIXED MONTHLY INCOME

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

4. ____________________:	$	$	$
5. ____________________:	$	$	$
C. TOTALS (A thru B):	**$**	**$**	**$**

SECTION 14 ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)
(Please provide copies of statements)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. (sample)	123-45-6789	Savings	$ 85,321.87	Jointly w/ son
			$	
			$	
			$	
			$	
			$	

B. SECURITIES (Bonds, Marketable Securities, etc.)
(Please provide copies of statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. (sample)	Common (or Preferred)	100 Shares	$ 5000	$ 9000	Sole owner
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)
(Please provide copies of statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker (sample)	123-45-678	Client	Spouse	Jan, 1970	$ 85,000.00
					$
					$
					$
					$
					$

D. REAL ESTATE
(Please provide copies of deeds and most recent tax bills)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
123 Know Way (sample)	$ 120,000	$ 180,000	$ 85,321.87	Joint tenant
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	

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 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. 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 15. 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 16. 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)
2.	______________________ (name of responsible person)	______________ (phone number)	______________ (relationship to person needing care)
3.	______________________ (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)
2.	______________________ (name of responsible person)	______________ (phone number)	______________ (relationship to person needing care)
3.	______________________ (name of responsible person)	______________ (phone number)	______________ (relationship to person needing care)

SECTION 17. UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

____

____

____

SECTION 18. 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):**	**$**	**$**	**$**

SECTION 19. 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
Acme Insurance (sample)	123-45-6789	Long-term care	$ 3,000	$ 300.00 per day
			$	$
			$	$
			$	$
			$	$

SECTION 20. 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
____________ (specify):	[ ] Yes [ ] No	[ ] Yes [ ] No

______________________________________: [ ] Yes [ ] No [ ] Yes [ ] No
(specify)

______________________________________: [ ] Yes [ ] No [ ] Yes [ ] No
(specify)

SECTION 21. TRANSFERS WITHIN 60 MONTHS

Has the person needing care transferred property to someone other than his or her spouse within the past 60 months? 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.		$	
3.		$	
4.		$	

B. Spouse

	Recipient	Amount/Value of Gift	Date of Gift
1.		$	
2.		$	
3.		$	
4.		$	

SECTION 22. TRANSFERS TO OR FROM TRUSTS

Has the person needing care 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.	______________________	$ ______________	________________
3.	______________________	$ ______________	________________

B. Spouse

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	______________________	$ ______________	________________
2.	______________________	$ ______________	________________
3.	______________________	$ ______________	________________

SECTION 23. CLIENT'S GOALS

What are your goals?

____

____

____

____

____

____

____

____

____