Zeldes, Needle & Cooper, P.C.

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.

DATED: _____

SECTION 1 - PERSONAL INFORMATION

	First	Middle	Last
Name of Person completing form:			
Home Address:			
Relationship to person(s) described below:			
Client's Full Name:			
Spouse's Full Name: (if applicable)			
Home Address:			

	Client	Spouse
Telephone Number:	(h)	(h)
	(c)	(c)
Date of Birth:		
Date and Place of Marriage:		
Former / Maiden Name(s):		
US Citizen	Yes _____ No _____	Yes _____ No _____
Social Security #:		
Military Service:		
If deceased, date of death:		

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SECTION 2. MARITAL INFORMATION

Date of Marriage: _____

Place of Marriage (City, State, Country): _____

If either spouse has been married before, please provide the date and place of divorce, if applicable:

Client:

Name of Former Spouse	Date of Marriage	Place of Marriage	Year Terminated

Spouse/Significant Other:

Name of Former Spouse	Date of Marriage	Place of Marriage	Year Terminated

If a former spouse is still alive, please list the name and describe the relationship with the former spouse:

SECTION 3. KEY FAMILY INFORMATION

Children (living and deceased). Indicate if adopted, and give the date adopted and the court granting adoption order. Indicate if deceased by putting "D" and give date of death next to name. Please indicate whether any deceased child left any surviving children.

A. Children of present marriage:

Name	Address	Phone Number(s)	Date of Birth	SS#
1.				
2.				
3.				
4.				

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B. Children of prior marriage: Client

Name	Address	Phone Number(s)	Date of Birth	SS#
1.				
2.				
3.				
4.				

C. Children of prior marriage: Spouse/Significant Other

Name	Address	Phone Number(s)	Date of Birth	SS#
1.				
2.				
3.				
4.				

D. Do any children have "special needs?" (Explain: Use back of sheet if necessary). For example, think about their health and general financial status, including needs and abilities.

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.)

1. Client #1:

To your Spouse/Significant other if he/she survives you? ☐ Yes ☐ No

If Spouse/Significant Other does not survive you:

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If neither Spouse/Significant Other, nor children survive you:

2. Client #2:

Does Spouse/Significant Other survive you? Yes ☐ No ☐

If Spouse/Significant Other does not survive you:

If neither Spouse/Significant Other nor children survive you:

3. Any specific disposition of your residence?

Client #1:

Client #2:

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

Client #1:

Client #2:

5. Household and personal effects:

Client #1:

Client #2:

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Include here any information that you think is important to your estate planning.

SECTION 5. FIDUCIARIES

Please consider the following information regarding the appointment of fiduciaries. Please give the name, address, telephone number and relationship, if any, of your chosen fiduciaries listed below. For each, specify order of preference of alternates by numbering. ***We will discuss this section at our conference and will assist you with the completion.***

	Name, Address and Telephone Number	Relationship
A1. Executor		
2. Co-Executor		
3. Successor Executor		

4. May surviving Co-Executor act alone? Yes _____ No _____

	Name, Address and Telephone Number	Relationship
B1. Trustee		
2. Co-Trustee		
3. Successor Trustee		

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4. May surviving Co-Trustee act alone? Yes _____ No _____

	Name, Address and Telephone Number	Relationship
C1. Trustee		
2. Co-Trustee		
3. Successor Trustee		

4. May surviving Co-Trustee act alone? Yes _____ No

	Name, Address and Telephone Number	Relationship
D1. Guardian of Minor		
2. Co-Guardian		
3. Successor Guardian		

4. May surviving Co-Guardian act alone? Yes _____ No _____

E1. Agent designated under Power of Attorney: Name and Address

2. Co-Agent under Power of Attorney: Name and Address

3. Should Agent and Co-Agent act separately or jointly?

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4. Designate Successor-Agent under Power of Attorney: Name and Address

5. Designate Agent under Health Care Proxy: Name, Address, and Telephone #

6. Designate Successor-Agent under Health Care Proxy: Name, Address and Telephone #

SECTION 6. HEALTH RELATED PROBLEMS

Health Problems: Client

Health Problems: Spouse/Significant Other

SECTION 7. CAPACITY

Are there any known problems with the individual's memory or understanding?

Client: Yes _____ No _____
Spouse/Significant Other: Yes _____ No _____

If you answered yes, please describe the nature of the problem:

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Please indicate Yes or No to the following questions:

	Client	Spouse/Significant Other
Is the individual able to sign his or her name?		
Able to speak?		
Able to recognize family members and acquaintances?		
Cognizant of his or her property and personal possessions?		
Able to travel outside his or her current place of residence?		

SECTION 8. PHYSICIAN'S INFORMATION

(Please list the name and address of your primary physician)

	Client	Spouse/Significant Other
Physician's Name:		
Specialty:		
Address:		
Business Telephone:		

SECTION 9. RESIDENCE – OWNED

A. Owner(s): _____

B. How is the title held? _____

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

C. Fair Market Value? $ _____

D. Outstanding Mortgage (list amount): $ _____

If so, is it a Reverse Annuity Mortgage (RAM)? Yes _____ No _____

Basic terms: _____

E. Single family residence? Yes _____ No _____

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

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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 of inheritance _____
2. Value on date of inheritance: (if available) $ _____

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

_____

_____

J. Has (have) the owner(s) used the principal residence capital gains tax exclusion? Yes _____ No _____

K. If at least one occupant of the residence is a child of the individual needing long-term care, has that child lived in the residence for at least two (2) years? Yes _____ No _____

1. Has the child provided personal care to the parent(s) that might have delayed the need for long-term care for the parent(s)? Yes _____ No _____

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

_____

_____

L. Do the individual(s) needing care have any living children who are disabled? Yes _____ No _____

If yes, please describe the nature of the disability:

_____

_____

M. If the owner has a brother or sister, has the brother or sister lived in the house for at least one (1) year? Yes _____ No _____

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

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SECTION 10. RESIDENCE – RENTED

Monthly Cost: $ _____

Type of rental: Single Family _____ Apartment _____
Residential Care _____ Life Care _____
Senior Housing _____

Is there a rental or lease agreement? Yes _____ No _____

Is the rent being subsidized? Yes _____ No _____

If so, by whom and for how much? _____ $ _____

SECTION 11. LONG-TERM CARE (LTC)

	Client	Spouse/Significant Other
Is the individual(s) currently receiving long-term care? *(please indicate yes or no)*		
If so, what was the date of entry into the nursing home or facility, or the date the home care was started?		

Name of the LTC facility/provider: _____

Address: _____

_____

Business Telephone: _____

Administrator or other contact: _____

SECTION 12. HOSPITAL

	Client	Spouse/Significant Other
Is either individual currently in a hospital? *Please indicate yes or no.*		
Name/Location of the Hospital:		
Date admitted:		

Please list the current duration of the hospital stay, and a brief description of the medical problem:

_____

_____

	Client	Spouse/Significant Other
Is placement in a LTC facility expected? *Please indicate yes or no.*		
If placement is expected, is it likely that he or		

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she will return home? _____

SECTION 13. INCOME

In completing the following section, use the "name on the check" rule, i.e., the individual(s) whose name appears on the payment vehicle is the "owner" of the income.

Fixed Monthly	Client	Spouse/Significant Other	Joint
Social Security	$	$	$
R.R. Retirement	$	$	$
Pension	$	$	$
Other (describe)			
_____	$	$	$
_____	$	$	$
Non-Fixed Monthly			
Interest	$	$	$
Dividends	$	$	$
Other (describe)			
_____	$	$	$
_____	$	$	$
TOTAL INCOME	$	$	$

SECTION 14. ASSETS/RESOURCES

Cash, CDs and Bank Balances:

Name of Bank/Branch	Account No.	Type of Account	Balance/ Current Value	How Title Held

Securities (Bonds, Marketable Securities, etc.): *(Or attach stock brokerage account statement)*

Company/Insurer	Type (Common/ Preferred)	No. of Shares/ Face Value	Cost	Current Value	How Title Held

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IRA, Keogh, and/or Other Retirement Plans ***(provide copies of plan documents and beneficiary designations)***:

Institution Where Held/Acct. No.	Owner	Beneficiary	Date Established	Current Value
#				$
#				$
#				$
#				$

Real Estate: ***Please provide us with a copy of the deed and most recent tax bill.***

Description (Location)	Title Held	Cost/Basis	Outstanding Mortgages	Market Value
1.				
2.				
3.				

Personal Property: ***(Indicate how ownership is held)***

	Value	How Held
Home Furnishings:	$	
Automobiles, Boats, etc.	$	
Jewels &/or furs:	$	
Other (collections, etc.)	$	

Business Interests:

If the individual(s) needing long-term care has any current 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.) of the business. Please bring a copy of any agreements, financial statements, etc.

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Rights or Interests in Trusts, Estates, or Prospective Inheritance:.

Briefly describe or give the name of the Trust in which the individual(s) 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.

Miscellaneous:
If either (or both) individual(s) needing long-term care has any property interests not described above, please explain the nature of the interest and the estimated value thereof:

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 individual needing care has the listed items: (please indicate yes or no)

	Client	Spouse/Significant Other
Burial plot: (Please provide a copy of deed)		
Irrevocable burial fund contract: (Please provide a copy)		

SECTION 16. RESPONSIBLE PERSONS

Who now has "assistance" responsibilities (i.e., are any family member or other individuals providing custodial or other types of care to the individual needing assistance)? Please list name, phone number, and relationship to the person receiving the care:

For Client:

For Spouse/Significant Other:

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SECTION 17. UNAVAILABLE CHILD(REN)

If the individual needing care has children, and any child(ren) are not to be relied upon for any reason to help with management or other needs of parent(s), please list name of such child(ren) and provide a short explanation why you believe such is the case: _____

_____

_____

SECTION 18. COST OF LIVING (ESTIMATED PER MONTH)

Housing	Client	Spouse/Significant Other	Joint
If home is owned, estimate total cost of mortgage, taxes, utilities, phone, etc.* (Monthly)	$	$	$
If rented, estimate monthly rental/lease expense (including any maintenance fees)	$	$	$
Insurance Premiums (Monthly)			
Health	$	$	$
Long-term care	$	$	$
Other (specify):	$	$	$
Medical Expenses			
Non-covered medications (monthly est.)	$	$	$
Other (specify):	$	$	$
	$	$	$
Basic Living Expenses			
Food	$	$	$
Entertainment & Travel	$	$	$
Support for child(ren)	$	$	$
Other (specify):	$	$	$
TOTALS	$	$	$

* Is the senior citizen real property tax exemption being used? Yes _____ No _____

Is the veterans real property tax exemption _____ _____

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being used? Yes _____ No _____

SECTION 19. HEALTH AND LTC INSURANCE

Use back of form if necessary (Please provide us with a copy of each document)

If either and/or both individual(s) have Medicare Parts A, B and/or D, private health or long-term care insurance, or are paying for a Medicare supplement policy, please provide the following information:

Name of Insurer and Policy #	Type of Policy	Monthly Premium	If LTC Insurance Daily Benefit
#		$	$
#		$	$
#		$	$
#		$	$

SECTION 20. PLANNING AND OTHER DOCUMENTS

Use back of form if necessary (Please provide us with a copy of each document)

Please indicate yes or no, and if you are supplying us with original or a copy.

	Client	Spouse/Significant Other
Will		
Durable Power of Attorney		
Health Care Proxy		
Living Will		
Trusts (Revocable)		
Trusts (other)		

SECTION 21. TRANSFERS WITHIN 60 MONTHS

Has the individual(s) transferred property to someone other than his or her spouse within the past sixty (60) months? If so, please provide the following information:

Client:

Recipient	Amount	Date
	$	
	$	

Gift tax returns filed on any gifts? (Please provide copies, if available) Yes or No

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Spouse/Significant Other:

Recipient	Amount	Date
	$	
	$	
	$	

Gift tax returns filed on any gifts? (Please provide copies, if available) Yes or No

SECTION 22. TRANSFERS TO OR FROM TRUSTS

Has the individual(s) transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past sixty (60) months?

Client: Yes _____ No _____

Spouse/Significant Other: Yes _____ No _____

If so, please provide the following information:

Name of Trust	Amount	Date
	$	
	$	

SECTION 23. GOALS OF CLIENT

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