

JULIAN GRAY ASSOCIATES

CERTIFIED ELDER LAW

AVOID MISTAKES. PROTECT ASSETS.

ELDERCARE PLANNING WORKSHEET

(PLEASE COMPLETE THIS PACKET IN INK)

This information packet must be returned to us at least three days prior to your meeting (this will ensure we have enough time to understand the specifics of your situation before our meeting). If you need assistance completing the information, call our office (412.269.9000) and we will help you.

DON'T WORRY ABOUT TOTAL ACCURACY – JUST DO THE BEST YOU CAN

WE LOOK FORWARD TO SEEING YOU!!!

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

Moon Township Office

1187 Thorn Run Road Ext., Suite 400
Moon Township, PA 15108
Phone: 412-269-9000

South Hills Office

2535 Washington Road, Suite 1111
Pittsburgh, PA 15241
Phone: 412-833-4400

www.GrayElderLaw.com
Fax: 412.269.9003

**ELDER CARE PLANNING QUESTIONNAIRE
(SINGLE)**

PLEASE BE AWARE no attorney client relationship has been formed by completing or not completing this questionnaire. If we do not receive your completed questionnaire within **thirty (30) days** from the date of receipt, we will close your file and Julian Gray Associates will take no further action on this matter.

Today's Date _____

This form is extremely important. Your accuracy and completeness in responding will help us to assess your situation.

A. PERSONAL DATA

Full Name _____

Street Address _____

City _____ County: _____ State _____ Zip _____

Telephone Number: _____ Email _____

Birth Date _____ Social Security No. _____

U.S. Citizen? Yes No Veteran? Yes No

Date of Discharge: _____

If widowed, please list name of spouse and date of death:

(Name of deceased spouse)

(Date of death)

Was your former spouse a Veteran? Yes No

If so, Date of Discharge from service: _____

**If available, please return a copy of military discharge papers with this questionnaire.*

B. MEDICAL DATA

1. PHYSICIAN

Full Name of Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

Telephone Number: _____

FOR FIRM USE ONLY:			RE#2	
LE			CASE TYPE	
CLR	CAV	FMV	AF	

2. STATE PHARMACEUTICAL PLAN

Are you currently on PACE or any other state pharmaceutical plan? Yes No

C. MONTHLY INCOME

**Do not include interest and dividend income on this form.*

Social Security Benefits (include \$96.40 Medicare Part B Deduction, if applicable)	\$ _____
Retirement Benefits (Gross)	\$ _____
Veterans Disability Income	\$ _____
Annuity Income	\$ _____
Rental Income	\$ _____
Other Income	\$ _____
TOTAL MONTHLY INCOME	\$ _____

If there is a pension, please list the **gross pension amount, including any monies deducted for federal income taxes, health insurance or any other reason.*

Could this pension amount increase in the future? Yes No

**COMPLETE SECTION D ONLY IF ALREADY RESIDING IN A FACILITY.*

D. MONTHLY COST OF INDEPENDENT/ASSISTED LIVING FACILITY/NURSING HOME

**Please indicate Independent Living, Assisted Living or Skilled Nursing Facility*

Name of Facility: _____

Facility Address: _____

City _____ County _____ State _____ Zip _____

Telephone Number _____

Monthly Cost \$ _____

Monthly Prescription Cost \$ _____

Monthly Incontinent Cost \$ _____

Monthly Other Cost \$ _____

Total Monthly Cost \$ _____

The facility is paid through _____ (month/year).

E. ADDITIONAL CARE GIVING SERVICES NEEDED

I need assistance with the following:

- | | | |
|---------------------------|------------------------------|-----------------------------|
| Assistance with bathing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Standing and sitting | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Getting in and out of bed | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Eating | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Walking | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Dressing and undressing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Taking medication | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Who is receiving care: _____

Name of Caregiver/Agency providing care: _____

How many hours per day / days per week is care received: _____

Monthly cost for care (if any) \$ _____.

F. MONTHLY NON-SHELTER LIVING EXPENSES

Please list any significant monthly non-shelter living expenses not disclosed in D above:

G. GIFTS

Have you made gifts in excess of \$500 in any one month, to an individual or group of individuals, within the past 60 months, or to a trust within the past 60 months? Yes No

If yes, list below:

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

If so, for what calendar year(s)? _____

H. LIFE INSURANCE/LONG TERM CARE INSURANCE

Name of Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

I. **CHILDREN** (if applicable, including adult children)

I have no Children

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____

Are all of your children in good health? Yes No

Are any of your children blind? Yes No

Are any of your children disabled? Yes No

Are any of your children receiving SSI or other form of government entitlement? Yes No

Do any of your family members have any problems with: Aids? Yes No

Drug Addiction? Yes No

Alcoholism? Yes No

Spendthrift? Yes No

Do any of your children live with you in your home? Yes No

If yes, name of child _____

Does a sibling live with you in your home? Yes No

If yes, name of sibling _____

Is anyone in your immediate or extended family disabled (including any spouses of your children): Yes No

If yes, name and relationship of disabled family member _____

J. <u>YOUR ADVISORS:</u>	<u>Name</u>	<u>Telephone No.</u>
Accountant	_____	_____
Life Insurance Agent	_____	_____
Investment Advisor	_____	_____
Other Attorney	_____	_____
Other Consultant or Advisor	_____	_____

K. MISCELLANEOUS

Do you own an irrevocable burial account? Yes No

Do you have a Medigap policy (supplemental health insurance)? Yes No

If yes, please list the name of the provider _____

and monthly premium \$ _____

Do you have any other legal issues which I should be aware of? Yes No

If yes, please explain.

L. REFERRAL

By whom were you referred to this office?

Name _____

Company Name: _____

Street Address _____

City _____ State _____ Zip _____

Have you visited our Website? Yes No

Do you have any ideas for improving our Website? If so, please discuss.

M. CERTIFICATION

The undersigned hereby represents to Gray Elder Law, LLC, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

Although reasonable value approximations are acceptable, it is important to be certain of the identity of all assets and how they are owned or titled. This Questionnaire provides for identification of assets as owned solely by wife, solely by husband, or as co-owned (either with a spouse or with another).

ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space.

ASSETS	SELF	JOINTLY HELD FUNDS	LIABILITIES
Personal Effects/Household Items	\$	\$	\$
Automobile	\$	\$	\$
Checking Account	\$	\$	\$
Savings Account	\$	\$	\$
Money Market Account	\$	\$	\$
Certificates of Deposit	\$	\$	\$
Residence (Assessed Value) Block # _____ Lot # _____ (Obtain from Tax Bill)	\$	\$	\$
Other Real Estate	\$	\$	\$
Additional Automobiles	\$	\$	\$
Mutual Funds	\$	\$	\$
Stocks	\$	\$	\$
Bonds	\$	\$	\$
Annuities	\$	\$	\$
Cash Value - Life Insurance	\$	\$	\$
IRA	\$	\$	\$
Nursing Home Deposit	\$	\$	\$
Other	\$	\$	\$
Other	\$	\$	\$
TOTALS	\$	\$	\$

What did you pay for your current home including any improvements? \$ _____

Do you own any real property other than personal residence? _____