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
(MARRIED)

Today's Date _____

This form is extremely important. Your accuracy and completeness in responding will help us to assess your situation. Bring this information with you to the appointment.

A. PERSONAL DATA

(Husband) **(Wife)**

Full Name _____ Full Name_____

Street Address_____

City _____County:_____ State _____ Zip_____

Telephone Number: _____ Email_____

(Husband) **(Wife)**

Birth Date _____ Birth Date _____

Social Security No. _____ Social Security No. _____

U.S. Citizen? Yes □ No □ U.S. Citizen? Yes □ No □

Veteran? Yes □ No □ Veteran? Yes □ No □

Date of Discharge: _____ Date of Discharge: _____

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

B. MEDICAL DATA

1. HEALTH

Name of Ill Spouse _____

Diagnosis _____

Prognosis _____ Course of Treatment _____

FOR FIRM USE ONLY:

HLE		
WLE		
CLR	CAV	FMV
RE#2		

If Ill Spouse has already entered an assisted living facility or nursing home, please indicate the date first entered on a continuous basis
Date Entered: _____
*Please indicate Assisted Living or Skilled Nursing Facility

Name of Facility:_____

Facility Addresss:_____

City_____County_____State_____Zip_____

Monthly Cost $_____

Monthly Prescription Cost $_____

Monthly Incontinent Cost $_____

Monthly Other Cost $_____

Total Monthly Cost $_____

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

Name of Well Spouse _____
Where Well Spouse Currently Resides _____
Health of Well Spouse _____

2. PHYSICIAN

Full Name of **Husband's** Primary Physician _____

Street Address _____

City _____County_____ State _____ Zip _____

Telephone Number:_____

Full Name of **Wife's** Primary Physician _____

Street Address _____

City _____County_____ State _____ Zip _____

Telephone Number:_____

3. 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.

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (include $96.40 Medicare Part B Deduction, if applicable)	$_____	$_____
Retirement Benefits (Gross)	$_____	$_____
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 □

E. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage	$_____
Real Estate Taxes	$_____
Homeowner's insurance premium	$_____
Condominium /Homeowner Assoc. fees	$_____
Total Monthly Housing Expenses	$_____

F. MONTHLY NON-SHELTER LIVING EXPENSES

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

_____

_____

G. GIFTS

Have you made gifts in excess of $500 in any one month to an individual or group of individuals, or transfer any funds to an individual or group of individuals, within the past 60 months, or to a trust within the past 60 months or were names removed from any bank, investment or financial accounts held jointly with another individual? Yes □ No □

If yes, list below:

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. <u>CHILDREN</u> (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 _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____
Phone Number _____ E-mail Address _____
Date of Birth _____

Does the Husband have any children by a previous marriage? Yes □ No □

Does the Wife have any children by a previous marriage? Yes □ No □

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 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 have an irrevocable burial account? Yes □ No □

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

If yes, please list the name of the provider _____
and monthly premium: __$_____

Do you have any other legal issues which we should be aware of: Yes □ No □

If yes, please explain _____

_____

L. REFERRAL

By whom were you referred to this office?

Name _____

Company Nmae:_____

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 in inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

_____

ASSETS/LIABILITIES

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

ASSETS	HUSBAND	WIFE	JOINT	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? $_____

Address of any real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____
Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)