JULIAN GRAY ASSOCIATES

ELDER LAW ♦ ESTATE & DISABILITY PLANNING

AVOID MISTAKES. PROTECT ASSETS.

ELDERCARE PLANNING QUESTIONNAIRE

(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 Client Relations Manager, Courtney Bachik, at (412-458-6000).

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

WE LOOK FORWARD TO SEEING YOU!!!

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

Julian Gray Associates
954 Greentree Road
Pittsburgh, PA 15220
Phone: 412-458-6000
Fax: 412-458-6015

www. GrayElderLaw.com

ELDER CARE PLANNING QUESTIONNAIRE
(MARRIED)

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

(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		
CASE TYPE		
AF		

If Ill Spouse has already entered an assisted living facility or nursing home, please indicate the date first entered on a continuous basis

*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 Caregiver Cost $_____

Total Monthly Cost $_____

Date entered facility _____ (month/day/year).

Medicare coverage ended / will end _____ (month/day/year)

The facility is paid through _____ (month/day/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 PACENET? 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 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 ☐

D. 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	$_____

E. ADDITIONAL CARE GIVING SERVICES NEEDED

I need assistance with the following:

Assistance with bathing	Yes ☐	No ☐
Standing and sitting	Yes ☐	No ☐
Getting in and out of bed	Yes ☐	No ☐
Eating	Yes ☐	No ☐
Walking	Yes ☐	No ☐
Dressing and undressing	Yes ☐	No ☐
Taking medication	Yes ☐	No ☐

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, 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)

Check this box if you have no living Children (adult or minors) ☐

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____
Date of Birth _____ Married? _____ Children?_____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____
Date of Birth _____ Married? _____ Children?_____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____
Date of Birth _____ Married? _____ Children?_____

Name of Child _____

Street Address _____

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

Name of Child _____

Street Address _____

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

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 government benefits such as Social Security disability, SSI, Medicaid or Veteran's Benefits? If so, please specify. Yes ☐ _____ No ☐

Do any of your family members have any problems with: 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. YOUR ADVISORS: **Name** **Telephone No.**

Accountant _____ _____

Life Insurance Agent _____ _____

Investment Advisor _____ _____

Other Attorney _____ _____

Other Consultant or Advisor _____ _____

K. CURRENT ESTATE PLAN

HUSBAND – Do you have any of the following estate planning documents?

Last Will & Testament Yes ☐ No ☐

Financial/General Durable Power of Attorney Yes ☐ No ☐ if yes, Agent: _____

Healthcare Power of Attorney/Living Will Yes ☐ No ☐ if yes, Agent: _____

Trusts Yes ☐ No ☐
If yes, name of Trust: _____

☐ I do not have any of the types of documents listed above.

WIFE – Do you have any of the following estate planning documents?

Last Will & Testament Yes ☐ No ☐

Financial/General Durable Power of Attorney Yes ☐ No ☐ if yes, Agent: _____

Healthcare Power of Attorney/Living Will Yes ☐ No ☐ if yes, Agent: _____

Trusts Yes ☐ No ☐
If yes, name of Trust: _____

☐ I do not have any of the types of the documents listed above.

L. SAFE DEPOSIT BOX

Do you have a Safe Deposit Box? Yes ☐ No ☐
If yes, please provide name of bank where it is located: _____

M. MISCELLANEOUS

Do you have an irrevocable burial fund? Yes ☐ No ☐
Do you own a cemetery plot or crypt? 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 own a firearm? Yes ☐ No ☐
Do you have a gun trust? Yes ☐ No ☐
Do you have any other legal issues which we should be aware of: Yes ☐ No ☐

If yes, please explain _____

_____

N. 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.

_____

_____

O. 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 <u>all</u> assets and <u>how they are owned or titled</u>. 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	HUSBAND	WIFE	JOINT	LIABILITIES
Personal Effects/Household Items	$	$	$	$
Automobile	$	$	$	$
Checking Account	$	$	$	$
Savings Account	$	$	$	$
Money Market Account	$	$	$	$
Certificates of Deposit	$	$	$	$
Residence (Assessed Value) Tax Parcel No._____ __ (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 <u>other</u> than personal residence? _____
Address: _____