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

SINGLE ELDER CARE PLANNING QUESTIONNAIRE*

***TO ALSO BE USED FOR UNMARRIED/DIVORCED/WIDOW/WIDOWER**

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:

LE		
CLR	CAV	FMV

RE#2		
CASE TYPE		
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 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, Personal Care Home or Skilled Nursing Facility*

Name of Facility:____

Facility Address:____

City________________________________County_________________________State________Zip__________

Telephone Number____

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).

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, 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)

Check this box if you have No living children (adult or minor) ☐

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? __________

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 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. <u>CURRENT ESTATE PLAN</u>

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.

L. <u>SAFE DEPOSIT BOX</u>

Do you have a Safe Deposit Box? Yes ☐ No ☐

If yes, please provide name of bank where it is located:____

M. <u>MISCELLANEOUS</u>

Do you own an irrevocable burial account? Yes ☐ No ☐

Do you own a cemetery plot or crypt? 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 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).

<u>ASSETS/LIABILITIES</u>

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 <u>other</u> than personal residence? ___________________________
Address:____