

# JULIAN GRAY ASSOCIATES

CERTIFIED ELDER LAW

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 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**

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### **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](http://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:		
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	\$ _____
<b>TOTAL MONTHLY INCOME</b>	<b>\$ _____</b>

*\*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** \$ \_\_\_\_\_

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 <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. YOUR ADVISORS:**                      **Name**                                      **Telephone No.**

Accountant                                      \_\_\_\_\_                                      \_\_\_\_\_

Life Insurance Agent                                      \_\_\_\_\_                                      \_\_\_\_\_

Investment Advisor                                      \_\_\_\_\_                                      \_\_\_\_\_

Other Attorney                                      \_\_\_\_\_                                      \_\_\_\_\_

Other Consultant or Advisor                                      \_\_\_\_\_                                      \_\_\_\_\_

**K. CURRENT ESTATE PLAN**

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 current estate planning documents.

**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 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.

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**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.

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**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:

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**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	\$	\$	\$
<b>TOTALS</b>	\$	\$	\$

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

Do you own any real property other than personal residence? \_\_\_\_\_

Address: \_\_\_\_\_