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

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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: _____

Preferred 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 ☐

Do you drive? Yes ☐ No ☐ Do you drive? Yes ☐ No ☐

Veteran? Yes ☐ No ☐ Veteran? Yes ☐ No ☐

Dates of Service: _____ Dates of Service: _____

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:

	Husband	Wife
CLR	CAV	FMV
CLR	CAV	FMV

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 Address: _____

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 or 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: _____ State: _____ Zip: _____

Telephone Number: _____

Full Name of Wife's Primary Physician: _____

Street Address: _____

City: _____ 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
Gross Social Security Benefits *(include Medicare Part B Premium)*	$_____	$_____
Gross Pension	$_____	$_____
Gross Retirement Benefit	$_____	$_____
Veterans Benefits Income	$_____	$_____
Annuity Income (non-IRA)	$_____	$_____
Rental Income	$_____	$_____
IRA Income (RMD's)	$_____	$_____
Other Income	$_____	$_____
TOTAL MONTHLY INCOME	$ 0	$ 0

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 Association Fees	$_____
TOTAL MONTHLY SHELTER EXPENSES	$ 0

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 Section D:

_____

_____

_____

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: $	_____
Recipient:	_____	Date:	_____	Amount: $	_____

Have you ever filed a Federal Gift Tax Return? (IRS Form 709) Yes ☐ No ☐

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

H. LIFE 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: $_______________

I. LONG-TERM CARE INSURANCE

Name of Insurance Company: ____ Policy: #___________________

Street Address: ____

City: ______________________________ State: ____________________ Zip: _____________

Type of Policy: ________________________________ Owner: ______________________________

Insured: _______________________________ Beneficiary: _______________________________

Daily Rate: $_________ Maximum Payment: $___________ Duration of Policy: ____________

Current Annual Premium: $___________________

J. 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? Yes ☐ No ☐ If Yes, please specify ____________________

Do any of your family members have any problems with:
Substance Abuse? Yes ☐ No ☐
Poor Financial Management? 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? Yes ☐ No ☐
(including any spouses of your children)
If yes, name and relationship of disabled family member: _____

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

Accountant: _____ _____

Life Insurance Agent: _____ _____

Investment Advisor: _____ _____

Other Attorney: _____ _____

Other Consultant or Advisor: _____ _____

J. 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 ☐ Who is POA? _____
Healthcare Power of Attorney/Living Will Yes ☐ No ☐ Who is POA? _____
Trust(s) Yes ☐ No ☐
If yes, name of Trust(s): _____

☐ 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 ☐ Who is POA? _____
Healthcare Power of Attorney/Living Will Yes ☐ No ☐ Who is POA? _____
Trust(s) Yes ☐ No ☐
If yes, name of Trust(s): _____

☐ I do not have any of the types of 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 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: _____

If yes, please list the monthly premium: _____

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

If yes, please explain below:

_____

_____

N. REFERRAL

How were you referred to our office?

Full 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.

_____

_____

Please complete the financial grid on the following page before signing below.

O. CERTIFICATION

The undersigned hereby represents to Julian Gray Associates and each of its attorneys that the information contained in this Eldercare Planning Questionnaire is accurate and complete. The undersigned also understands that Julian Gray Associates and its individual lawyers will rely on this information. The undersigned understands that if the information contained herein is inaccurate or incomplete, the recommendations made by Julian Gray Associates 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	HUSBAND	WIFE	JOINTLY HELD FUNDS	LIABILITIES
Automobile	$	$	$	$
Additional Automobile	$	$	$	$
Checking/Savings Account(s)	$	$	$	$
Money Market Account	$	$	$	$
Certificates of Deposit	$	$	$	$
Residence (Assessed Value) Tax Parcel No._____ __ (Obtain from Tax Bill)	$	$	$	$
Other Real Estate	$	$	$	$
Non-IRA Mutual Funds, Stocks Bonds	$	$	$	$
Non-IRA Annuities	$	$	$	$
Cash Value - Life Insurance	$	$	Not Applicable	Not Applicable
401K	$	$	Not Applicable	Not Applicable
IRA Mutual Funds, Stocks, Bonds	$	$	Not Applicable	Not Applicable
IRA Annuities	$	$	Not Applicable	Not Applicable
Other	$	$	$	$
Other	$	$	$	$
TOTALS	$ 0	$ 0	$ 0	$ 0

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

Does your property have any preferential tax treatment? Yes ☐ No ☐

Do you own any real property other than personal residence? Yes ☐ No ☐

If Yes, please list Address: _____