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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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: _____

Preferred Telephone Number: _____ Email: _____

Birth Date: _____ Social Security No.: _____

U.S. Citizen? Yes ☐ No ☐ Veteran? Yes ☐ No ☐

Do you drive? Yes ☐ No ☐ Dates of Service: _____

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, Dates of 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
CLR	CAV	FMV

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.

Gross Social Security Benefits *(include Medicare Part B Premium)*	$_____
Gross Pension	$_____
Veterans Benefits Income	$_____
Annuity Income (non-IRA)	$_____
Rental Income	$_____
IRA Income (RMD's)	$_____
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 Facility Cost	$_____
Monthly Other Facility Related Costs (Prescriptions, Caregiver, Incontinence)	$_____
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).

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, 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? (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: _____ _____

L. 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 ☐ 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.

M. SAFE DEPOSIT BOX

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

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

N. 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 of which we should be made aware? Yes ☐ No ☐

If yes, please explain below:

_____

_____

O. REFERRAL

How were you referred to our office?

Full Name: _____

Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Have you visited our Website? Yes ☐ No ☐

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

P. 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 Eldercare Planning Questionnaire provides for identification of assets as owned by an individual or co-owned with another.

ASSETS/LIABILITIES

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

ASSETS	SELF	JOINTLY HELD FUNDS	LIABILITIES
Automobile	$	$	$
Additional Automobile	$	$	$
Checking/Savings Account(s)	$	$	$
Money Market Account(s)	$	$	$
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	$	$	$

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: _____