ROBLES LAW, P.A.

ELDER CARE PLANNING QUESTIONNAIRE

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

_____

Relationship to Client: _____

Client's Full Name: _____
(first) (middle) (last)

Spouse's Full Name: _____
(first) (middle) (last)

Home Address: _____

_____

	Client	**Spouse**
Telephone Numbers:	_____ (home)	_____ (home)
	_____ (cell)	_____ (cell)
Date of Birth:	_____	_____
Former/Maiden Names:	_____	_____
US Citizen?:	☐ Yes ☐ No	☐ Yes ☐ No
Social Security Number:	_____	_____
Military Service:	_____	_____
Date of Death:	_____	_____

CLIENT'S GOALS

What are your goals?

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

_____

_____

_____

B. Spouse

_____

_____

_____

CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: ☐ Yes ☐ No

Spouse: ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

B. OTHER ISSUES

	Client		Spouse	
Able to sign name?:	☐ Yes	☐ No	☐ Yes	☐ No
Able to speak?:	☐ Yes	☐ No	☐ Yes	☐ No
Able to recognize friends and family?:	☐ Yes	☐ No	☐ Yes	☐ No
Cognizant of property and possessions?:	☐ Yes	☐ No	☐ Yes	☐ No
Able to leave current residence?:	☐ Yes	☐ No	☐ Yes	☐ No

PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of your primary physician.

	Client	Spouse
Physician's Name:	_____	_____
Specialty:	_____	_____
Address:	_____	_____
	_____	_____
Business Phone:	_____	_____

MARITAL INFORMATION

A. Date of Marriage: _____

B. Place of Marriage: _____
(city) (state or province) (country)

C. Client's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ ☐ Death ☐ Divorce
(year terminated) (how terminated)

☐ Yes ☐ No _____
(still living?) (if still living, describe relationship)

2. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ ☐ Death ☐ Divorce
(year terminated) (how terminated)

☐ Yes ☐ No _____
(still living?) (if still living, describe relationship)

D. Spouse's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ ☐ Death ☐ Divorce
(year terminated) (how terminated)

☐ Yes ☐ No _____
(still living?) (if still living, describe relationship)

2. _____ (name of former spouse) _____ (date of marriage) _____ (place of marriage)

_____ (year terminated) ☐ Death ☐ Divorce (how terminated)

☐ Yes ☐ No (still living?) _____ (if still living, describe relationship)

CHILDREN

List all children. Copy and attach additional pages, if needed. Total number of children: _____

1. _____ (name of child) _____ (date of birth) _____ (social security number)

Parent: ☐ Client ☐ Spouse ☐ Both

_____ (current address) _____ (phone number)

☐ Adopted _____ (date of adoption) _____ (court granting adoption)

☐ Deceased _____ (date of death) ☐ Yes ☐ No (child has surviving children?)

_____ (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

2. _____ (name of child) _____ (date of birth) _____ (social security number)

Parent: ☐ Client ☐ Spouse ☐ Both

_____ (current address) _____ (phone number)

☐ Adopted _____ (date of adoption) _____ (court granting adoption)

☐ Deceased _____ (date of death) ☐ Yes ☐ No (child has surviving children?)

_____ (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

3. _____ (name of child) _____ (date of birth) _____ (social security number)

Parent: ☐ Client ☐ Spouse ☐ Both

_____ (current address) _____ (phone number)

☐ Adopted _____ (date of adoption) _____ (court granting adoption)

☐ Deceased _____ (date of death) ☐ Yes ☐ No (child has surviving children?)

_____ (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

4. _____ (name of child) _____ (date of birth) _____ (social security number)

Parent: ☐ Client ☐ Spouse ☐ Both

_____ (current address) _____ (phone number)

☐ Adopted _____ (date of adoption) _____ (court granting adoption)

☐ Deceased _____ (date of death) ☐ Yes ☐ No (child has surviving children?)

_____ (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

5. _____ _____ _____
(name of child) (date of birth) (social security number)
Parent: ☐ Client ☐ Spouse ☐ Both

_____ _____
(current address) (phone number)
☐ Adopted _____ _____
(date of adoption) (court granting adoption)
☐ Deceased _____ ☐ Yes ☐ No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

6. _____ _____ _____
(name of child) (date of birth) (social security number)
Parent: ☐ Client ☐ Spouse ☐ Both

_____ _____
(current address) (phone number)
☐ Adopted _____ _____
(date of adoption) (court granting adoption)
☐ Deceased _____ ☐ Yes ☐ No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

_____
_____
_____

RESIDENCE – OWNED

A. Owners: _____
B. How is title held? _____
C. Fair Market Value: $ _____
D. Mortgage Balance: $ _____
Is it a Reverse Annuity Mortgage (RAM)? ☐ Yes ☐ No
Basic Mortgage Terms: _____
E. Single Family Residence? ☐ Yes ☐ No
F. If the property is rental property, please provide the following:
1. Number of units: _____
2. Currently being rented? ☐ Yes ☐ No
3. Are tenants under lease? ☐ Yes ☐ No

G. If the property was purchased, please provide the following:
1. Date of Purchase: _____
2. Purchase Price: $ _____

H. If the property was inherited, please provide the following:
1. Month/Year Inherited: _____
2. Value when Inherited: $ _____

I. If improvements have been made to the property, please detail the value and nature of them:

_____

_____

_____

J. Have the owners used the capital gains tax exclusion? ☐ Yes ☐ No

K. If at least one occupant of the residence is a child of the individual in need of long-term care, has that child lived in the residence for at least 2 years? ☐ Yes ☐ No

1. If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? ☐ Yes ☐ No

2. If so, please describe the nature and duration of the care provided:

_____

_____

_____

L. Does the person needing care have any living children who are disabled? ☐ Yes ☐ No
If yes, please describe the nature of the disability:

_____

_____

M. Does the owner have a sibling who has lived in the house for at least 1 year? ☐ Yes ☐ No
If yes, does the sibling still reside in the home? ☐ Yes ☐ No

RESIDENCE – RENTED

A. Monthly Rent: $ _____

B. Type of Rental: ☐ Single Family ☐ Apartment ☐ Residential Care ☐ Life Care ☐ Senior Housing

C. Rental/Lease Agreement? ☐ Yes ☐ No

D. Is Rent Subsidized? ☐ Yes ☐ No

If so, by whom and amount? _____

LONG-TERM CARE (LTC)

A. Client

Currently Receiving LTC? ☐ Yes ☐ No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

B. Spouse

Currently Receiving LTC? ☐ Yes ☐ No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

HOSPITAL

A. Client

Currently in Hospital? ☐ Yes ☐ No
If so, date admitted: _____
Name/location of hospital: _____
Description of medical issue: _____
Is LTC placement expected? ☐ Yes ☐ No
If so, likely to return home? ☐ Yes ☐ No

B. Spouse

Currently in Hospital? ☐ Yes ☐ No
If so, date admitted: _____
Name/location of hospital: _____
Description of medical issue: _____
Is LTC placement expected? ☐ Yes ☐ No
If so, likely to return home? ☐ Yes ☐ No

DEBT

Enter the outstanding balance of debt. For a married couple, be sure to include both spouses' debt.

Description/Type of Debt	Whose debt?	Creditor	Balance
			$
			$
			$
			$
			$
			$

INCOME

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment vehicle is the "owner" of the income.

A. FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Social Security:	$	$	$
2.	R.R. Retirement:	$	$	$
3.	Pension:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$
6.	_____:	$	$	$

B. NON-FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Interest:	$	$	$
2.	Dividends:	$	$	$
3.	_____:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$
C.	**TOTALS (A thru B):**	**$**	**$**	**$**

ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.) (Please provide copies of statements)

Name of Bank/Branch	Last 4 Account #	Type of Account	Balance/Value	How Title Held
			$	
			$	
			$	
			$	
			$	

B. SECURITIES (Bonds, Marketable Securities, etc.) (Please provide copies of statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.) (Please provide copies of statements)

Name of Institution	Last 4 Account #	Owner	Beneficiary	Date Est.	Current Value
					$
					$
					$
					$
					$

D. REAL ESTATE (Please provide copies of deeds and most recent tax bills)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	

E. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$	
Cars, RVs, Boats, etc.:	$	
Jewels, Furs, etc.:	$	
: (other: collectibles, etc.)	$	
:	$	
:	$	

F. BUSINESS INTERESTS

Please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which the person needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

_____

_____

_____

_____

H. MISCELLANEOUS

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each (but not life insurance—see Section 20).

_____

_____

_____

_____

EXEMPT RESOURCES

	Client		Spouse	
Burial plot:	☐ Yes	☐ No	☐ Yes	☐ No
Irrevocable burial fund contract:	☐ Yes	☐ No	☐ Yes	☐ No

PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance?

A. Responsible for Client:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

3. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

B. Responsible for Spouse:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

3. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

	Client	Spouse	Joint
1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*:	$ _____	$ _____	$ _____
2. If home is rented, total rent, including maint. fees, if any:	$ _____	$ _____	$ _____

* Is the senior citizen real property tax exemption being used? ☐ Yes ☐ No
Is the veterans real property tax exemption being used? ☐ Yes ☐ No

B. INSURANCE PREMIUMS (PER MONTH)

		Client	Spouse	Joint
1.	Health insurance:	$	$	$
2.	Long-term care insurance:	$	$	$
3.	_____ (specify):	$	$	$
4.	_____ (specify):	$	$	$

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Non-covered medications:	$	$	$
2.	_____ (specify):	$	$	$
3.	_____ (specify):	$	$	$

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Food:	$	$	$
2.	Entertainment and travel:	$	$	$
3.	Support for children:	$	$	$
4.	_____ (specify):	$	$	$
5.	_____ (specify):	$	$	$
E.	**TOTALS (A thru D):**	**$**	**$**	**$**

HEALTH AND LTC INSURANCE

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
			$	$
			$	$
			$	$

LIFE INSURANCE

If the person needing care has life insurance, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	Cash Surrender Value
			$	$
			$	$
			$	$

PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	Client		Spouse	
Will:	☐ Yes	☐ No	☐ Yes	☐ No
Revocable Living Trust:	☐ Yes	☐ No	☐ Yes	☐ No
Pour-Over Will:	☐ Yes	☐ No	☐ Yes	☐ No
General Durable Power of Attorney:	☐ Yes	☐ No	☐ Yes	☐ No
Health Care Power of Attorney (or Proxy):	☐ Yes	☐ No	☐ Yes	☐ No

Living Will:	☐ Yes	☐ No	☐ Yes	☐ No
_____:	☐ Yes	☐ No	☐ Yes	☐ No
_____:	☐ Yes	☐ No	☐ Yes	☐ No
_____:	☐ Yes	☐ No	☐ Yes	☐ No

(specify)

TRANSFERS WITHIN 60 MONTHS

Has the person needing care (or spouse) gratuitously transferred property to someone other than spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**: Please include transfers for financial assistance to anyone, other than in exchange for work.

A. Client

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

B. Spouse

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

TRANSFERS TO OR FROM TRUSTS

Has the person needing care (or spouse) transferred property into a Trust—like an Irrevocable Life Insurance Trust (ILIT)—or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

A. Client

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

B. Spouse

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____