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Confidential Long Term Care/Medi-Cal Planning Information Sheet

This questionnaire is to obtain background information necessary to help us advise you about your Long-Term Care/Medi-Cal planning options. The more complete and accurate your responses, the better we can serve you. Feel free to attach extra sheets if necessary.

It would be very helpful if you could send us the completed form before our first meeting. Please also try to bring to the first meeting copies of any wills, trusts, and deeds. Powers of Attorney, and other legal papers you may have. Please feel free to contact me with any questions.

NOTE: **Reference to the "client" refers at all times to the elder in need**. Throughout our representation, we have only one client – the elder. If a client seeks the assistance of a family member or other person to assist them with our representation, please have that "contact person" fill out his/her information on page 3.

A. CLIENT INFORMATION:

a. Name (include middle initial)	_____
b. Residence Address	_____
	_____
c. Home Phone	(_____) _____
Cell-Phone?	(_____) _____
Fax No.	(_____) _____
….E-mail address	_____
e. Date of Birth	_____
f. Citizenship	_____
g. Social Security #	_____
h. Date of Marriage	_____
i. Occupation	_____
j. Retirement Date	_____
k. U.S. Citizen?	Yes __ No ___
l. Veteran?	Yes __ No ___
m. **Presently in facility?**	Yes __ No ___
If so:	
n. Name of Facility:	_____
o. Address of facility:	_____
p. Type of facility:	_____
q. Level of Care:	_____
r. Date of admission:	_____

B. CHILDREN/OTHER DEPENDENTS:

Name	Address	Contact 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
If yes: How much is the child's monthly payment? $_____
Is the child receiving Medicaid or Medicare? ___ Medicaid ___ Medicare

Do any of your family members have any problems with:

AIDS?	___ Yes ___ No	Alcoholism Drug Addiction?	___ Yes __ No
Alcoholism?	___ Yes ___ No	Marital Difficulty?	___ Yes __ No

Dependents other than YOU?

Is anyone dependent upon the person-in-need for support? If so, please identify the person and describe the reason for, and extent of, support provided:

Name/Age	Relationship	Support Amount	Reason for support
_____	_____	$ _____	_____
_____	_____	$ _____	_____

Other present occupants in your home?

Does a child, parent, sibling, or other family member currently live in your home? Yes __ No __

Name of Occupant	Relationship	Date of Birth	Amount of Support (Month)
_____	_____	__/__/_____	$ _____
_____	_____	__/__/_____	$ _____

Have any of your children or brothers or sisters lived with you during the past 2 years? Yes __ No __

C. CONTACT PERSON INFORMATION:

a. Name (include middle initial)	_____
b. Residence Address	_____
	_____
c. Home Phone	(_____) _____
Cell-Phone?	(_____) _____
Fax No.	(_____) _____
….E-mail address	_____
Relationship to client	_____

D. HEALTH STATUS:

Your health status plays an important role in the designing of a long term care plan best suited for you and your loved one.

CURRENT HEALTH STATUS: **Good** **Concern** **Problem**

Specific Concern / Problem / Hospitalization:

_____

_____

_____

Please tell me a little about your health, if you both live at home now, and how long you plan to stay in your own home.

_____

_____

_____

_____

PHYSICIAN

Full Name of Husband's Primary _____

Address_____ Tel No.: _____
City, State, Zip

E. MONTHLY INCOME: **(Please divide annual income by 12 and quarterly income by 3)**

	Client
a. Work Earnings	$ _____
b. Social Security Retirement	$ _____
c. Social Security Disability	$ _____
d. Supplemental Security Income	$ _____
e. Veterans' Benefits	$ _____
f. Private Pension ***	$ _____
g. Annuity Income	$ _____
h. Regular Support from Others	$ _____
i. Unemployment Compensation	$ _____
j. Worker's Compensation	$ _____
k. Regular Income from Trust	$ _____
l. Rental Income	$ _____
m. Interest and Dividends	$ _____
n. Business Interest	$ _____
o. Other	$ _____
TOTALS	$ _____

*** If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason. Do not include interest and dividend income on this form.

Please provide a copy of the federal income tax returns for you and your spouse for the last two years.

F. VETERAN(S)

Are you or a prior spouse a veteran? Yes ___ No ___ If yes, please provide the following information:

	Client	**Prior Spouse (if applicable**
a. Military Service	_____	_____
b. Serial Number	_____	_____
c. Dates of Service	_____	_____
d. VA Claim Number	_____	_____
e. Branch of Service	_____	_____

Please describe any veteran's benefits you or your spouse are now receiving:

_____

G. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost $_____

Monthly Prescription Cost $_____

Monthly Incontinent Cost $_____

Monthly Medical Insurance Cost (Ill Spouse Only) $_____

Monthly Other Cost $_____

Total Monthly Cost $_____

The nursing home is paid through _____ (month/year).

H. HEALTH INSURANCE

	"Well" Spouse (Client)
a. Medicare	Yes __ No __ (# _____)
b. Medicare Supp Insurance	Yes __ No __ (# _____)
	Company: _____
c. Medi-Cal	Yes __ No __ (# _____)
d. Long Term Care Insurance	Yes __ No __ (# _____)
	Company: _____
e. Other	_____

I. GIFTS

Have you made gifts in excess of $500 in any one month, to an individual or group of individuals, within the past 36 months, or to a trust within the past 60 months? ___ Yes ___ No

If yes, list below:

Recipient	**Date**	**Amount**
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____

Have you ever filed a Federal Gift Tax Return? ___ Yes ___ No

If yes, please state details

_____

_____

J. LEGAL

	"Well" Spouse (Client)
a. Will	Yes ___ No ___
b. Living Trust	Yes ___ No ___
c. Durable Power of Attorney for Finances?	Yes ___ No ___
d. Durable Power of Attorney for Heath Care?	Yes ___ No ___
e. Conservatorship	Yes ___ No ___
f. I am legally appointed guardian for :	Name: _____
g. I am legally appointed conservator for:	Name: _____
h. I am the agent under a power of attorney for	Name: _____
i. I am the executor/administrator for estate of	Name: _____

K. Current Lawsuits/Liens?

Is any of your property or income the subject of a legal proceeding or ownership dispute, under a lien or court order, or otherwise inaccessible or non-marketable? Yes __ No __ If yes, please explain briefly:

_____

_____

_____

_____

L. Other legal concerns:

_____

_____

M. Future changes in personal/financial situation?

Describe any significant changes that you or your spouse anticipate occurring over the next 5 years with respect to your (i) personal, marital, or family situation, (ii) employment or (iii) financial situation as it relates to your level of income, debt or assets.

_____

_____

_____

_____

_____

N. CERTIFICATION

The undersigned hereby represents to the Law Practice of Patrick McNally, and each of its Attorneys and Staff members, 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:

_____

Please bring copies of the following documents with you to our first meeting:

- Any current will(s), codicil(s), living trust or other trust agreements.
- Copies of real estate deeds with appraisals, if available.
- Admission agreements to hospitals and health facilities.
- Conservatorship documents.
- Living will, health care declaration or power of attorney, durable powers of attorney
- A list of full names, addresses, telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries of your estate, helpers', and advisors.
- Copies of tax returns for you and your spouse for the last two years.

LONG TERM CARE PLANNING -ADDITIONAL INFORMATION

YOUR ASSETS/LIABILITIES

"**TITLE**": Indicate the Title of each asset as follows: (SEP) Separate; (JT) Joint Tenancy; (TIC) Tenancy-in-Common and (?) Don't Know.

Real Estate

Indicate after the address the **Type** of property - Residence (R); Rental (L) or vacation (V)

Address & Type	Title	Purchase Price	Year Bought	Present Value	Your Equity
1. _____ _____	_____	$ _____	_____	$ _____	$ _____
2. _____ _____	_____	$ _____	_____	$ _____	$ _____
3. _____ _____	_____	$ _____	_____	$ _____	$ _____
4. _____ _____	_____	$ _____	_____	$ _____	$ _____

Bank & Savings And Loan Accounts

Indicate the **Type** of account: (S) Savings; (C) Checking; (CD) Certificate of Deposit; and (O) Other.

Institution and Branch	Account No.	Title	Type	Value
1. _____	_____	_____	_____	$ _____
2. _____	_____	_____	_____	$ _____
3. _____	_____	_____	_____	$ _____
4. _____	_____	_____	_____	$ _____

Money Market Accounts/Mutual Funds and/or similar accounts

Brokerage Firm & Branch	Account No.	Title	Type	Value
1. _____	_____	_____	_____	$ _____
2. _____	_____	_____	_____	$ _____
3. _____	_____	_____	_____	$ _____
4. _____	_____	_____	_____	$ _____

Stocks & Bonds

(e.g. common stock, preferred stock, corporate bonds, commodities, municipal bonds, government savings bonds, treasury bills, limited partnership interests, mutual funds)

List each security that you own. Indicate number of stock, the current value, and how title to the security is held (e.g. IBM; common stock; 10,000; John Smith and Kevin Daniels; 6/98; $10,000):

Stock Name	Type	Number	Title	Year Bought	Present Value
1. _____	_____	_____	_____	_____	$ _____
2. _____	_____	_____	_____	_____	$ _____
3. _____	_____	_____	_____	_____	$ _____
4. _____	_____	_____	_____	_____	$ _____

Personal Property: (Autos, RVs, boats, antiques, heirlooms, jewelry, collections, etc.)

Description of Property	Title	Value
1. _____	_____	$ _____
2. _____	_____	$ _____
3. _____	_____	$ _____
4. _____	_____	$ _____
5. _____	_____	$ _____
6. _____	_____	$ _____

Miscellaneous Property: (Includes Cash & negotiables in Safe Deposit Box; accounts receivable; Leases Franchises held; Royalty Income; Patents, trademark, and copyrights held; Stock Options; Oil, gas or mineral rights)

Description of Property	Title	Value
1. _____	_____	$ _____
2. _____	_____	$ _____
3. _____	_____	$ _____
4. _____	_____	$ _____
5. _____	_____	$ _____
6. _____	_____	$ _____

Loans/Promissory Notes owed to you:

Name of Debtor	Original Note Value	Secured?	Amount Due
1. _____	$ _____	Yes/No	$ _____
2. _____	$ _____	Yes/No	$ _____
3. _____	$ _____	Yes/No	$ _____
4. _____	$ _____	Yes/No	$ _____

Retirement Plans and Annuities:

Do you have IRAs, pension plans, profit-sharing, stock bonus, retirement plan, or deferred compensation plan, or any other similar type of benefit? :

"Type": IRA; 401(k); 403(b); Keogh; SEP IRA; Co.-P (Company Pension); P-S (Profit-Sharing)

Name of Plan/Company	Designated Beneficiary	Type	Vested?	Value
1. _____	_____	_____	Yes/No	$ _____
2. _____	_____		Yes/No	$ _____
3. _____	_____		Yes/No	$ _____
4. _____	_____		Yes/No	$ _____

Annuities: (List any annuities you own, the estimated value and whether the annuity is tax-deferred)

Company	Owner	Tax-Deferred	Est. Value
1. _____	$ _____	Yes/No	$ _____
2. _____	$ _____	Yes/No	$ _____

Business Interests: Do you own a business? Have an interest in a Partnership?

Business Name: _____ Type of Entity (Corp (C); sole prop (SP); partnership (P) ___

Nature of business and location _____

Percent interest : ___ Value of interest $ _____ Date interest acquired _____

Tax basis on interest (if known) $ _____ Is interest jointly owned? _____

If so, please describe : _____

What are your wishes as to disposition of ownership after death? _____

1. Transfer to Family Yes/No 2. Sale to co-owner of business Yes/No

3. Sale of key-employee Yes/No 4. Other: _____

Is there a buy-sell or redemption agreement? Yes/No

Life Insurance:

Insurance Company	Policy Owner	On Whose Life	Beneficiary	Value
1. _____	_____	_____	_____	$ _____
2. _____	_____	_____	_____	$ _____
3. _____	_____	_____	_____	$ _____
4. _____	_____	_____	_____	$ _____

Other Investments:

Description of Investment	Who Owns?	Value
1. _____	_____	$ _____
2. _____	_____	$ _____

Non U.S. Assets:

Description and location of Asset	Who Owns?	Value
1. _____	_____	$ _____
2. _____	_____	$ _____

Liabilities: (mortgages, notes to banks, notes to others, loans on insurance, other)

"Who owes": (SEP) Separate; (J) Joint

Creditor	Who Owes	Amount Owed
1. _____	_____	$ _____
2. _____	_____	$ _____
3. _____	_____	$ _____
4. _____	_____	$ _____
5. _____	_____	$ _____
6. _____	_____	$ _____

RELATIVES TO BE GIVEN NOTICE (Within 2nd Degree) – COURT PETITION – DO NOT COMPLETE BEFORE INITIAL CONSULTATION

If a court Petition is to be filed with the court, relatives within the "2nd degree" of the "ill-spouse" must be notified. Relatives "within the 2nd degree" include the ill-spouse's parents, grandparents, children, grandchildren, and brothers and sister. Please fill out the list below with a COMPLETE list of all those people within the ill-spouse's 2nd degree, **including those who have predeceased the ill-spouse, indicating under "address" that they are deceased.** Children need not be included as their information should already have been completed on the second page of this Questionnaire.

Name	**Address**	**Relationship**
_____	_____ _____	Father
_____	_____ _____	Mother
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____

If there are more names than can be accommodated above, please make an extra sheet and complete that.

VA AID & ATTENDANCE

DO NOT COMPLETE BEFORE INITIAL CONSULTATION

Veteran(s)

1. Is the ill spouse one of the following?

☐ Veteran

☐ Spouse of Veteran

☐ Spouse of Deceased Veteran

☐ Dependent Child of Veteran

2. The Veteran served in one of the following:

☐ U.S. Army ☐ U.S. Navy ☐ U.S. Air Force ☐ U.S. Marines ☐ U.S. Coast Guard ☐ Merchant Marine during WWII

2. Did the Veteran serve at least 90 days of consecutive active duty? ☐ Yes ☐ No

3. Did the Veteran serve at least 1 (one) day during wartime? ☐ Yes ☐ No

If yes, indicate which wartime:

☐ WWI – April 6, 1917 thru November 11, 1918 (or if in Russia April 1, 1920)

☐ WWII – December 7, 1941 thru December 31, 1946

☐ Korean War – June 27, 1950 thru January 31, 1955

☐ Vietnam War – August 5, 1064 thru May 7, 1975

☐ Gulf War – August 2, 1990 to date

5. Did the Veteran receive a discharge other than dishonorable? ☐Yes ☐No

Please be sure to bring your DD-214 Discharge Papers to our office at your next appointment!

6. Is the Veteran either 65 years of age or older or 100% permanently and totally disabled and was the disability caused without willful misconduct by the Claimant? ☐Yes ☐No

7. The Claimant is one of the following:

☐ House-bound

If House-bound, is Claimant blind?

If House-bound, does client need help with Activities of Daily Living such as ☐ Bathing

☐ Dressing ☐ Feeding ☐ Transferring from chair to bed or from bed to chair

☐ Toileting ☐ Continence

☐ In an assisted living facility

☐ In a nursing home

8. Is Claimant blind ☐Yes ☐No or suffering from macular degeneration ☐Yes ☐No?

9. Is Claimant diagnosed with dementia? ☐Yes ☐No? Stage: Early Mid Late