

Hill Law Group, PA
ELDER PLANNING QUESTIONNAIRE
(For a MARRIED couple)

NOTE: The main people this form is about is the person who is intended to receive assistance (Ill Spouse) and their spouse (Well Spouse). This form is extremely important. Your accuracy and completeness in responding will help us best represent you. Bring this information with you to your appointment.

Date _____ File No. _____

CONTACT INFORMATION

If the "Contact person" is different from the "Client," please complete this section:

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Work Phone No. _____

Cell Number _____ Fax Number _____

E-Mail Address _____

Which the best way to communicate with you? ___ Phone ___ Email

Is this also the person completing this form? ___ yes ___ no

How did you hear about this office? ___ internet ___ advertisement ___ friend ___ Attorney

___ facility employee (if a person) Name _____

CLIENT INFORMATION (The Couple for whom we are planning)

(Husband)

(Wife)

Full Name _____ Full Name _____

Street Address _____

City _____ State _____ Zip _____

Date Married: _____

(Husband)

(Wife)

Birth Date _____ Birth Date _____

Social Security No. _____ Social Security No. _____

U.S. Citizen? ___ Yes ___ No U.S. Citizen? ___ Yes ___ No

Veteran? ___ Yes ___ No Veteran? ___ Yes ___ No

For what war? _____ For what war? _____

MEDICAL-HEALTH INFORMATION

For HUSBAND: Please give a brief description of your current activity level or condition.

Include a diagnosis if known. _____

Where are you living now? _____ Home _____ Assisted Living _____ Nursing Home

If you are already in a nursing home or Assisted Living Facility:

Name of home: _____ Date Entered _____

Are you receiving Rehabilitation under Medicare? _____ Yes _____ No _____ I don't know

Full Name of Husband's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

For WIFE:

Please give a brief description of your current activity level or condition. Include a diagnosis if known. _____

Where are you living now? _____ Home _____ Assisted Living _____ Nursing Home

If you are already in a nursing home or Assisted Living Facility:

Name of home: _____ Date Entered _____

Are you receiving Rehabilitation under Medicare? _____ Yes _____ No _____ I don't know

Full Name of Wife's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

RELATIONSHIPS

If the key people in you life are your children, please skip to "children" below.

If not, please tell us who the key people in your life are and your relationship.

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

CHILDREN (If applicable, include adult and minor children)

Name of Child 1 _____ Gender: ___ Male ___ Female

Relationship to husband: ___ Natural child ___ Adopted ___ Stepchild

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___

Name of Child 2 _____ Gender: ___ Male ___ Female

Relationship to husband: ___ Natural child ___ Adopted ___ Stepchild

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___

Name of Child 3 _____ Gender: ___ Male ___ Female

Relationship to husband: ___ Natural child ___ Adopted ___ Stepchild

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___

Name of Child 4 _____ Gender: ___ Male ___ Female

Relationship to husband: ___ Natural child ___ Adopted ___ Stepchild

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___

If more children, please list on another page.

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 you 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

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 _____

DOCUMENTS IN PLACE: Please list the person who is the primary and secondary representative for each:

HUSBAND:

Power of Attorney Rep 1 _____

____ Yes ____ No Rep 2 _____

Health Care Surrogate Rep 1 _____

____ Yes ____ No Rep 2 _____

Will Rep 1 _____

____ Yes ____ No Rep 2 _____

Trust Rep 1 _____

____ Yes ____ No Rep 2 _____

Do you have a Living Will? ____ Yes ____ No

WIFE:

Power of Attorney Rep 1 _____

____ Yes ____ No Rep 2 _____

Health Care Surrogate Rep 1 _____

____ Yes ____ No Rep 2 _____

Will Rep 1 _____

____ Yes ____ No Rep 2 _____

Trust Rep 1 _____

____ Yes ____ No Rep 2 _____

Do you have a Living Will? ____ Yes ____ No

ASSETS/LIABILITIES **Assets are things you own.** Please be sure to list everything you own. If there is not a space for it, place it in “Other” at the end. If we provide services beyond our initial consultation we will ask you for documentation on each asset. You may want to begin organizing those documents now. Liabilities are debts such as loans or mortgage notes. *Please fill in the value of the asset/liability below*

| ASSET/LIABILITY | YES/ NO | JOINT ASSET | HUSBAND'S ASSET | WIFE'S ASSET | LIABILITY |
|--|------------|-----------------|--------------------|-----------------|------------------------|
| <i>Example - Automobile 2006</i> | <i>yes</i> | <i>\$25,000</i> | | | <i>\$15,600 (loan)</i> |
| PERSONAL EFFECTS | | | | | |
| HOMESTEAD (TAX VALUE) Folio # _____ | | | | | |
| AUTOMOBILE(S) | | | | | |
| | | | | | |
| TRADITIONAL IRA/RETIREMENT PLAN | | | | | |
| | | | | | |
| | | | | | |
| ROTH IRA | | | | | |
| PREPAID FUNERAL PLAN | | | | | |
| | | | | | |
| CEMETERY PLOT(S) | | | | | |
| | | | | | |
| CHECKING ACCOUNTS | | | | | |
| | | | | | |
| | | | | | |
| SAVINGS ACCOUNTS | | | | | |
| | | | | | |
| | | | | | |
| MONEY MARKET ACCOUNTS | | | | | |
| | | | | | |

| ASSET/LIABILITY | YES/ NO | JOINT ASSET | HUSBAND'S ASSET | WIFE'S ASSET | LIABILITY |
|--------------------------------------|------------|----------------|--------------------|-----------------|-----------|
| CERTIFICATES OF DEPOSIT | | | | | |
| | | | | | |
| | | | | | |
| OTHER REAL ESTATE LOCATION: _____ | | | | | |
| MINERAL RIGHTS | | | | | |
| | | | | | |
| BROKER/CAP ACCOUNTS | | | | | |
| | | | | | |
| MUTUAL FUNDS | | | | | |
| | | | | | |
| STOCKS | | | | | |
| | | | | | |
| BONDS | | | | | |
| | | | | | |
| ANNUITIES | | | | | |
| (Also see insurance page) | | | | | |
| LIFE INS. - Cash Value | | | | | |
| (Also see insurance page) | | | | | |
| | | | | | |
| OTHER: | | | | | |
| OTHER: | | | | | |
| OTHER: | | | | | |
| TOTAL FROM PREVIOUS PAGE | | | | | |
| TOTAL | | | | | |

LIFE INSURANCE AND/OR ANNUITIES

Life insurance can have several different values associated with it. We are particularly interested in the “Cash Value” or the value of it if you cashed it out today and the “Death Benefit” the amount it will pay on your death. Policies often issue annual statements. If you do not have a recent one, you may need to call the life insurance company in order to obtain this information.

PLEASE MAKE AS MANY COPIES OF THIS PAGE AS YOU NEED TO COMPLETE INFORMATION ON EACH POLICY

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 ANNUITY Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Annuity _____ Owner _____
Annuitant _____ Beneficiary _____
Purchase Amount:\$ _____ Cash Value:\$ _____
Date Purchased : _____ Maturity Date: _____ Date Annuitized: _____

Name of ANNUITY Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Annuity _____ Owner _____
Annuitant _____ Beneficiary _____
Purchase Amount:\$ _____ Cash Value:\$ _____
Date Purchased : _____ Maturity Date: _____ Date Annuitized: _____

CLOSED BANK/FINANCIAL ACCOUNTS

Have you closed any banking or financial accounts in the past three (3) years?

_____yes _____no

If you have please complete the following:

| Account Location (Name of Institution) | Type of Account | Date Closed | Where did funds go to? |
|---|-----------------|-------------|------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

GIFTS

Have you made gifts in excess of \$1,000 in any one month, to an individual or group of individuals, or to a Trust within the past 5years (60 Months)? ___Yes ___No

If yes, list below:

Recipient _____ Date _____ Amount _____
 Recipient _____ Date _____ Amount _____
 Recipient _____ Date _____ Amount _____
 Recipient _____ Date _____ Amount _____
 Recipient _____ Date _____ Amount _____

GROSS MONTHLY INCOME

Please list the **gross, before tax, amount**, including any monies taken out for health insurance, or any other reason.

| | Husband's | Wife's |
|-------------------------------------|-----------------|----------------------|
| (HARD INCOME) | Monthly Income | Monthly Income _____ |
| Social Security Benefits | \$ _____ | \$ _____ |
| Pension/Retirement Benefits (Gross) | \$ _____ | \$ _____ |
| Employment | \$ _____ | \$ _____ |
| Veterans Disability Income | \$ _____ | \$ _____ |
| Annuity Income | \$ _____ | \$ _____ |
| Rental Income | \$ _____ | \$ _____ |
| TOTAL MONTHLY INCOME | \$ _____ | \$ _____ |

(FLEXIBLE INCOME)

| | | |
|--------------------------------|----------|----------|
| Income from Dividends/interest | \$ _____ | \$ _____ |
| Other _____ | \$ _____ | \$ _____ |

MONTHLY HEALTH INSURANCE COSTS (for Ill Spouse)

| | | |
|----------------------------------|-----------------|-----------------|
| Medicare Part A \$ _____ | Part B \$ _____ | Part D \$ _____ |
| Medicare Choice (HMO) Co. _____ | | \$ _____ |
| Supplemental Insurance Co. _____ | | \$ _____ |
| Long Term Care Co. _____ | | \$ _____ |
| Other Health Insurance Co. _____ | | \$ _____ |

MONTHLY COST OF NURSING HOME OR ASSISTED LIVING (for Ill Spouse)

| | |
|--|-----------------|
| Monthly Nursing Home/ALF Cost | \$ _____ |
| Monthly Prescription Medication Cost | \$ _____ |
| Monthly Incontinent/ Personal Items Cost | \$ _____ |
| Monthly Other Cost | \$ _____ |
| TOTAL Monthly Cost | \$ _____ |

Date of Admission to Nursing Home _____

MONTHLY HEALTH INSURANCE COSTS (for Well Spouse)

Medicare Part A \$ _____ Part B \$ _____ Part D \$ _____
Medicare Choice (HMO) Co. _____ \$ _____
Supplemental Insurance Co. _____ \$ _____
Long Term Care Co. _____ \$ _____
Other Health Insurance Co. _____ \$ _____

MONTHLY HOME EXPENSES (For Well Spouse)

_____ (Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage \$ _____
Real Estate Taxes \$ _____
Water \$ _____
Sewer \$ _____
Utilities (Heat, Electric & Telephone) \$ _____
Homeowner's insurance premium \$ _____
Condominium fees \$ _____
Total Monthly Housing Expenses \$ _____

MISCELLANEOUS

Do you have any other legal issues which we should be aware of? ___ Yes ___ No

If yes, please explain _____

CERTIFICATION

The undersigned hereby represents to Hill Law Group, PA and each of its attorneys that the information contained in this intake form is 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 or accurate. Signature of Client or Client Representative:

_____ Date

The statement below is to be signed by the client or elder in need of services if other persons are attending meeting on their behalf.

I, _____, and/or _____ hereby authorize all attorneys and staff at HILL LAW GROUP, PA to communicate with and advise the following individual(s) on my behalf:

| | Name | Relationship |
|----|-------|--------------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |

I further declare that I understand that, once information is shared with the above named individuals, Hill Law Group, PA cannot be responsible for the acts or statements made by the above named individuals.

_____ Husband

_____ Date

_____ Wife

_____ Date