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.______________________

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____

<u>**CLIENT INFORMATION (The Couple for whom we are planning)**</u>

(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: ________________________

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

<u>ASSETS/LIABILITIES</u> **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 each asset/liability below

ASSET/LIABILITY	YES/ NO	JOINT ASSET	HUSBAND'S ASSET	WIFE'S ASSET	LIABILITY
Example - Automobile 2006	*yes*	*$25,000*			*$15,600 (loan)*
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:					
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" or 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.

(HARD INCOME)	Husband's Monthly Income	Wife's 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