

Hill Law Group, PA
ELDER PLANNING QUESTIONNAIRE
(For a SINGLE person)

NOTE: The main person this form is about is the person who is intended to receive assistance. All questions that ask about "you" refer to the person intended to receive assistance. This form is extremely important. Your accuracy and completeness in responding will help me 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 (Person intended to receive assistance)

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-Mail Address _____

Birth Date _____ Social Security No. _____

Are you a U.S. Citizen? ___Yes ___No Are you a Veteran? ___Yes ___No

If widowed, please list name of spouse and date of death

Was your former spouse a Veteran? ___Yes ___No

MEDICAL DATA - HEALTH

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

Where are you living now? _____

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

Name of Facility _____

Date Entered _____

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

INSURANCE

What types of health insurance do you have?

____ Medicare ____ A ____ B Date coverage began _____

____ Medicare Part D- Prescription Drug coverage

Provider: _____

____ HMO

Provider: _____

____ Medicare Supplemental Insurance

Provider: _____

____ Long Term Care Insurance

Provider: _____

____ Cobra

____ Other Health Insurance _____

PHYSICIAN

Full Name of Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

RELATIONSHIPS

If the key people in your 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: ___Natural child ___Adopted ___Stepchild

Name of Child 2 _____ Gender: ___Male ___Female

Relationship: ___Natural child ___Adopted ___Stepchild

Name of Child 3 _____ Gender: ___Male ___Female

Relationship: ___Natural child ___Adopted ___Stepchild

Name of Child 4 _____ Gender: ___Male ___Female

Relationship: ___Natural child ___Adopted ___Stepchild

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 _____

ASSETS/LIABILITIES Assets are things you own. 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, but it is not necessary.

Please fill in the value of each asset group

TYPE OF ASSET	YES/NO	VALUE	LOCATION
<i>Example: Automobile 2006</i>	Yes	\$25,000	
HOMESTEAD (TAX VALUE)			
AUTOMOBILE(s)			
Total IRAs/401Ks/ RETIREMENT PLANS			
PREPAID FUNERAL PLANS			
LIFE INSURANCE POLICIES			
Total in all Bank Accounts			
Total Investments			
All Other Assets			
TOTAL			

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 5 years (60 months)? Yes No

MONTHLY COST OF NURSING HOME OR ASSISTED LIVING

Nursing Home/ALF Cost \$ _____
Prescription Medication Cost \$ _____
Incontinent/ Personal Items Cost \$ _____
Other Cost \$ _____
TOTAL MONTHLY EXPENSES \$ _____

MONTHLY INCOME

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

Social Security Benefits	\$ _____
Pension Benefits (Gross)	\$ _____
IRAs (RMD)	\$ _____
Veterans Disability Income	\$ _____
Annuity Income	\$ _____
Rental Income	\$ _____
Income from Dividends/Interest	\$ _____
Other _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____

DOCUMENTS IN PLACE

If you have any of these documents, please bring with you:

Durable Power of Attorney, Health Care Surrogate, Living Will, Will and Trust

MISCELLANEOUS

Do you have any other legal issues which we should be aware of? ___Yes ___No

If yes, please provide brief details:

What are your primary questions or concerns that you are coming to Hill Law Group for?

