**NAME OF CLIENT:** ______________________________
**DATE OF CONSULTATION:**__________________________
____________________________________________________

# Life Care Planning Design Questionnaire

Pittman Law Office

PLEASE RETURN THE COMPLETED QUESTIONNAIRE TO OUR OFFICE 48 HOURS PRIOR TO YOUR APPOINTMENT VIA HAND DELIVER, EMAIL, OR MAIL. CONSULTATION WILL BE RESCHEDULED IF QUESTIONNAIRE IS NOT PROVIDED TO OUR OFFICE 48 HOURS PRIOR TO CONSULTATION.

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

Our regular office hours are Monday thru Thursday, from 8:00 AM to 4:00 PM.
***We are closed on Fridays.***


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# Pittman Law Office

CONFIDENTIAL

DATE: ______________________________

## SECTION 1. NAME AND CONTACT INFORMATION

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: | ____________ | ____________ |
| Date of Death: | ____________ | ____________ |

## SECTION 2. MILITARY INFORMATION

**SERVICE INFORMATION**

Military Service: Client ___________________________________ Spouse ____________________________

Has the veteran received any of the following? (list all that apply)

Lump Sum Readjustment Pay $ _______________________________

Separation Pay $ _______________________________

Special Separation Benefit $ _______________________________

Voluntary Separtation Incentive $ _______________________________

Disability Severance Pay $ _______________________________

The Veteran is (check all that apply)

□ On Medal of Honor Roll

□ Receiving VA compensation for service-connected disability

□ Receiving military retirement pay $ ________________ branch: __________________________

□ Formerly a POW (please give a short description below)

_____________________________________________________________________________________

_____________________________________________________________________________________

## SECTION 3. DISABILITY INFORMATION

| Client | Spouse | |
|---|---|---|
| □ | □ | Over 65 |
| □ | □ | Blind |
| □ | □ | Declared incompetent |
| □ | □ | Has macular degeneration – Extent: ______________________________ |
| □ | □ | Under 65, determined disabled by Social Security Administration |
| □ | □ | Diagnosed with dementia – Stage: Early Mid Late |
| □ | □ | Is housebound (unable to leave without assistance) |

□ □ Needs daily assistance from another to perform basic activities

□ □ Receives Medicaid – Type:________________________________________

□ □ Has applied for Medicaid – Type: __________________________________

□ □ Is in nursing home – Name:_______________________________________

□ □ Is in an assisted living facility – Name: ____________________________

## SECTION 4. MARITAL INFORMATION

**A.** Date of Marriage: ______________________________________________________________

**B.** Place of Marriage: ______________________________________________________________

(city) (state or province) (country)

**C. Client's Former Spouse:**

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| (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 Spouse:**

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| (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) | |



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## SECTION 5. 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

Married [ ] Single [ ] Widowed [ ] Other ________________________________________

________________________________________ ______________________
(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)

________________________________________________________________
(Use additional pages, if needed)

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

Parent: [ ] Client [ ] Spouse [ ] Both

Married [ ] Single [ ] Widowed [ ] Other ________________________________________

________________________________________ ______________________
(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)

________________________________________________________________
(Use additional pages, if needed)



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

Parent: [ ] Client [ ] Spouse [ ] Both

Married [ ] Single [ ] Widowed [ ] Other ________________________________________

________________________________________ ____________________
(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)

________________________________________
(Use additional pages, if needed)

## SECTION 6. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

**A. Client**

________________________________________

________________________________________

________________________________________

**B. Spouse**

________________________________________

________________________________________

________________________________________

## SECTION 7. 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 |

## SECTION 8. PHYSICIAN INFORMATION

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

| | **Client** | **Spouse** |
|---|---|---|
| Physician's Name: | ____________________ | ____________________ |
| Specialty: | ____________________ | ____________________ |
| Address: | ____________________ | ____________________ |
| | ____________________ | ____________________ |
| Business Phone: | ____________________ | ____________________ |

## SECTION 9. RESIDENCE -- OWNED

**A.** Owners: ______________________________

**B.** How is title held? ______________________________

**PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL**

**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



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## SECTION 10. 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? ______________________________

## SECTION 11. 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: ______________________________

## SECTION 12. 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

## SECTION 13. 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.** 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): $ __________ $ __________ $ __________**

## SECTION 14. ASSETS AND RESOURCES

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

| Name of Bank/Branch | Account No. | Type of Account | Balance/Value | How Title Held |
|---|---|---|---|---|
| Big Bank/Main St. (sample) | xxx-xxxx | Savings | $ xx,xxx.xx | Jointly w/ son |
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |

**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 |
|---|---|---|---|---|---|
| Acme Corp. (sample) | Common (or Preferred) | xx Shares | $ x,xxx.xx | $ x,xxx.xx | Sole owner |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |

**C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)**
**(Please provide copies of statements and beneficiary designations)**

| Name of Institution | Account No. | Owner | Beneficiary | Date Est. | Current Value |
|---|---|---|---|---|---|
| Big Broker (sample) | xxx-xxxx | Client | Spouse | Jan, 1970 | $ xx,xxx.xx |
| | | | | | $ |
| | | | | | $ |



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| | | | | | |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |

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

| Description (Location) | Cost (Basis) | Market Value | Mortgage Bal. | How Title Held |
|---|---|---|---|---|
| 123 Know Way (sample) | $ xxx,xxx.xx | $ xxx,xxx.xx | $ xx,xxx.xx | Joint tenant |
| | $ | $ | $ | |
| | $ | $ | $ | |
| | $ | $ | $ | |
| | $ | $ | $ | |
| | $ | $ | $ | |

**E. PERSONAL PROPERTY**

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

**F. BUSINESS INTERESTS**

If the person needing long-term care has any 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.

______________________________

______________________________

______________________________

______________________________



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## 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.

## SECTION 15. EXEMPT RESOURCES

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

| | **Client** | **Spouse** |
|---|---|---|
| Burial plot: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Irrevocable burial fund contract: | [ ] Yes [ ] No | [ ] Yes [ ] No |



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## SECTION 16. 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? Please list name, phone number, and relationship to the person receiving the care.

**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)

## SECTION 17. 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.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## SECTION 18. 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.*: | $ ______________ | $ ______________ | $ ______________ |



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| | | Client | Spouse | Joint |
|---|---|---|---|---|
| **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):** | **$** | **$** | **$** |

## SECTION 19. 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 |
|---|---|---|---|---|
| Acme Insurance (sample) | 123-45-6789 | Long-term care | $ 3,000 | $ 300.00 per day |
| | | | $ | $ |



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| | | | | |
|---|---|---|---|---|
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |

## SECTION 20. 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 |
| Designation of Health Care Surrogate (or Proxy): | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Living Will: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| ____________________: (specify) | [ ] Yes [ ] No | [ ] Yes [ ] No |
| ____________________: (specify) | [ ] Yes [ ] No | [ ] Yes [ ] No |
| ____________________: (specify) | [ ] Yes [ ] No | [ ] Yes [ ] No |

## SECTION 21. TRANSFERS WITHIN 60 MONTHS

Has the person needing care transferred property to someone other than his or her spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**:

**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.** | | $ | |



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| | | | |
|---|---|---|---|
| **3.** | | $ | |
| **4.** | | $ | |

## SECTION 22. TRANSFERS TO OR FROM TRUSTS

Has the person needing care transferred property into a Trust, 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.** | | $ | |

## SECTION 23. CLIENT'S GOALS

What are your goals?



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