**ELDER LAW**

**PLANNING QUESTIONNAIRE**

**(Married)**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART A: PERSONAL INFORMATION**

**CLIENT HUSBAND:**

|  |  |  |
| --- | --- | --- |
| Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ |
| Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | U.S. Citizen? Yes \_\_\_\_\_ No \_\_\_\_\_ |

**CLIENT WIFE:**

|  |  |  |
| --- | --- | --- |
| Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_ |
| Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | U.S. Citizen? Yes \_\_\_\_\_ No \_\_\_\_\_ |

**CHILDREN:**

Are any of your children blind? YES \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_

Are any of your children disabled? YES \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_

Do any of your children live with

You in your home? YES \_\_\_\_\_\_\_ NO \_\_\_\_\_\_\_

**PART B: MISCELLANEOUS INFORMATION**

Age of Husband \_\_\_\_\_\_\_\_\_\_

Age of Wife \_\_\_\_\_\_\_\_\_\_

If either spouse is in a nursing home or contemplates entering a nursing home, please list the following:

Name of ill spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Course of Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART C: MONTHLY INCOME**

Gross Salary or Wages $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Benefits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(include $46.10 Medicare Part

B Deduction, if applicable)

Retirement Benefits \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interest \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dividends \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOTAL MONTHLY INCOME: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is a pension, please list the gross pension amount and the name of the Company or Governmental entity paying the pension.

Gross Amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (include all deductions)

Name of Company or Governmental Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART D: GIFTS**

(Gifts made in excess of $1,000/year to an individual other than your spouse within the past 36 months.)

Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART E: ASSETS**

(Please insert the approximate value of each asset/liability in the appropriate space)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ASSETS** | **HUSBAND** | **WIFE** | **JOINT** | **LIABILITIES** |
| Personal Effects | $ | $ | $ | $ |
| Automobile |  |  |  |  |
| Business Interest |  |  |  |  |
| Checking Account |  |  |  |  |
| Savings Account |  |  |  |  |
| Money Market Account |  |  |  |  |
| Savings Certificate |  |  |  |  |
| Residence (Assessed Value) |  |  |  |  |
| Additional Automobiles |  |  |  |  |
| Other Real Estate |  |  |  |  |
| Mutual Funds |  |  |  |  |
| Stocks |  |  |  |  |
| Bonds |  |  |  |  |
| Annuities |  |  |  |  |
| Cash Value-Life Insurance |  |  |  |  |
| IRA |  |  |  |  |
| Other |  |  |  |  |
| Other |  |  |  |  |
|  |  |  |  |  |
| **TOTAL ASSETS/LIABILITIES** | **$** | **$** | **$** | **$** |

Address of any real property other than personal residence:

Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Tax Block # \_\_\_\_\_\_\_\_\_\_\_\_\_, Lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (can be obtained from Tax Bill)

Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Tax Block # \_\_\_\_\_\_\_\_\_\_\_\_\_, Lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (can be obtained from Tax Bill)

Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Tax Block # \_\_\_\_\_\_\_\_\_\_\_\_\_, Lot # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (can be obtained from Tax Bill)

What is your cost basis for your personal residence? $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART F: LIFE INSURANCE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **COMPANY**  (include address  and policy number) | **TYPE** | **FACE VALUE** | **CASH VALUE** | **INSURED** | **OWNER** | **BENEFICIARY** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**It is very important to know the cash value of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent or call the insurance company directly.**

(Include the cash value of the life insurance on the Life Insurance line in Part E.)

**PART G: MONTHLY HOUSING EXPENSES**

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

Mortgage $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rent $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Taxes $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Water $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sewer $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Utilities (Heat & Electric – 1/12 of the last 12 months) $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homeowner’s Insurance Premium $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condominium Fees $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOTAL MONTHLY HOUSING EXPENSES** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART H: MONTHLY COSTS OF NURSING HOME**

Cost per Month $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescription Costs per Month $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incontinent Costs per Month $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Costs per Month $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOTAL MONTHLY COSTS OF NURSING HOME** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART I: MONTHLY NON-SHELTER LIVING EXPENSES**

Food $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clothing $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transportation $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Maintenance $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Life Insurance Premiums $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Premiums $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cable TV $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOTAL MONTHLY NON-SHELTER**

**LIVING EXPENSES**  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART J: CHILDREN**

|  |  |  |  |
| --- | --- | --- | --- |
| **CHILDREN’S NAMES** | **ADDRESS, CITY, ST, ZIP** | **TELEPHONE NUMBER** | **DATE OF BIRTH** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**PART K: REFERRAL**

By whom were you referred to this office:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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