# Hill & Kinsella
# 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_____

CLIENT INFORMATION (The Couple for whom we are planning)

| (Ill Spouse/Spouse 1) | (Well Spouse/Spouse 2) |
|---|---|
| Full Name_____ | Full Name_____ |
| Street Address_____ | |
| City_____State_____Zip_____ | |

Date Married: _____

| (Ill Spouse/Spouse 1) | (Well Spouse/Spouse 2) |
|---|---|
| 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 ILL SPOUSE/SPOUSE 1:* 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 Ill Spouse/Spouse 1's Primary Physician_____

Street Address_____

City_____State_____Zip_____

*For WELL SPOUSE/SPOUSE 2:* 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 Well Spouse/Spouse 2'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 Ill Spouse/Spouse 1: ___Natural child ___Adopted___ Stepchild

Relationship to Well Spouse/Spouse 2: ___Natural child ___Adopted ___Stepchild

Name of Child 2_____Gender: ___Male ___Female

Relationship to Ill Spouse/Spouse 1: ___Natural child ___Adopted___ Stepchild

Relationship to Well Spouse/Spouse 2: ___Natural child ___Adopted ___Stepchild

Name of Child 3_____Gender: ___Male ___Female

Relationship to Ill Spouse/Spouse 1: ___Natural child ___Adopted___ Stepchild

Relationship to Well Spouse/Spouse 2: ___Natural child ___Adopted ___Stepchild

Name of Child 4_____Gender: ___Male ___Female

Relationship to Ill Spouse/Spouse 1: ___Natural child ___Adopted___ Stepchild

Relationship to Well Spouse/Spouse 2: ___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:

**ILL SPOUSE/SPOUSE 1:**

**Power of Attorney** Named Agent_____

____ Yes ____ No Date executed_____

**Health Care Surrogate** Named Agent_____

____ Yes ____ No Date executed_____

**Will** Personal Representative_____

____ Yes ____ No Date executed_____

**Trust** Trustee/Successor_____

____ Yes ____ No Date executed_____

Do you have a Living Will? ____ Yes ____ No

**WELL SPOUSE/SPOUSE 2:**

**Power of Attorney** Named Agent_____

____ Yes ____ No Date executed_____

**Health Care Surrogate** Named Agent_____

____ Yes ____ No Date executed_____

**Will** Personal Representative_____

____ Yes ____ No Date executed_____

**Trust** Trustee/Successor_____

____ Yes ____ No Date executed_____

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 each asset/liability below*

| ASSET/LIABILITY | YES/ NO | JOINT ASSET | ILL SPOUSE/SPOUSE 1'S ASSET | WELL SPOUSE/SPOUSE 2'S ASSET | LIABILITY |
|---|---|---|---|---|---|
| *Example - Automobile 2020* | *yes* | *$25,000* | | | *$15,600 (loan)* |
| PERSONAL EFFECTS | | | | | |
| HOMESTEAD (TAX VALUE)<br>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 | ILL SPOUSE/SPOUSE 1'S ASSET | WELL SPOUSE/SPOUSE 2'S ASSET | LIABILITY |
|---|---|---|---|---|---|
| CERTIFICATES OF DEPOSIT | | | | | |
| | | | | | |
| | | | | | |
| OTHER REAL ESTATE LOCATION:_____ __ | | | | | |
| MINERAL RIGHTS | | | | | |
| BROKER/CAP ACCOUNTS | | | | | |
| | | | | | |
| MUTUAL FUNDS | | | | | |
| | | | | | |
| STOCKS (not with a Financial Institution) | | | | | |
| | | | | | |
| BONDS | | | | | |
| ANNUITIES | | | | | |
| (Also see insurance page) | | | | | |
| LIFE INS. - Cash Value | | | | | |
| (Also see insurance page) | | | | | |
| 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.

| | Ill Spouse/Spouse 1's Monthly Income | Well Spouse/Spouse 2's Monthly Income |
|---|---|---|
| **(HARD 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.

_____ _____
Ill Spouse/Spouse 1 Date

_____ _____
Well Spouse/Spouse 2 Date