

**HKH Elder Law
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)

(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

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	HUSBAND'S ASSET	WIFE'S ASSET	LIABILITY
<i>Example - Automobile 2006</i>	<i>yes</i>	<i>\$25,000</i>			<i>\$15,600 (loan)</i>
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_____

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 III 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 III 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 HKH Elder Law 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, HKH Elder Law cannot be responsible for the acts or statements made by the above named individuals.

_____ Date _____
Husband

_____ Date _____
Wife