HKH Elder Law
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
Example: Automobile 2006	*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 HKH Elder Law for?

_____

_____

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