Hill & Kinsella
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:

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What are your primary questions or concerns that you are coming to Hill Law Group for?

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