



**LONG TERM CARE PLANNING QUESTIONNAIRE
(SINGLE)**

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to your appointment.

Person Completing Questionnaire: _____

For Whom: _____

Relationship: _____

Phone No: _____ Cell: _____

A. CLIENT DATA

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security No. _____

Home phone: _____ Other number: _____

U.S. Citizen? ___ Yes ___ No

Veteran? ___ Yes ___ No

If yes, service during
wartime? _____

If widowed, please list name of spouse and date of death: _____

B. MEDICAL DATA

1. HEALTH

Diagnosis/Current Medical Condition:

If you are already in a nursing home:

Name of Nursing Home _____

Date Entered _____

Medicare: Yes/No

Secondary insurance: Yes/No

If yes, which company: _____

Medicare HMO: Yes/No

If yes, which HMO: _____

2. PHYSICIAN

Full Name of Primary
Physician _____

Street Address _____

City _____ State _____ Zip _____

Phone Number: _____

3. STATE PHARMACEUTICAL PLANS

If you are a Veteran, are you currently receiving
prescription benefits from the Veteran's Administration? ___ Yes ___ No

C. MONTHLY INCOME

	Monthly Income
Social Security Benefits (include \$88.50 Medicare Part B Deduction, if applicable)	\$ _____
Retirement Benefits (Gross)	\$ _____
VA Disability Benefit	\$ _____
Annuity Income	\$ _____
Rental Income	\$ _____
TOTAL MONTHLY INCOME	\$ _____

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Do not include interest and dividend income on this form.

D. MONTHLY SHELTER EXPENSES

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

Rent/Mortgage	\$ _____
Real Estate Taxes	\$ _____
Residential Facility	\$ _____
Utilities (heat, electric, water and sewer) (1/12th of last 12 months)	\$ _____
Homeowner's insurance premium	\$ _____
Condominium fees/maintenance	\$ _____
Total Monthly Housing Expenses	\$ _____

E. MONTHLY NON-SHELTER LIVING EXPENSES

Groceries	\$ _____
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Prescriptions	\$ _____
Clothing	\$ _____
Auto operation (gas/maintenance)	\$ _____
Auto Insurance	\$ _____
Home Maintenance	\$ _____
Life Insurance Premiums	\$ _____
Health Insurance Premium (Medicare Supp.)	\$ _____
Cable TV	\$ _____
Recreation, vacation, entertainment	\$ _____
Charitable contributions	\$ _____
Private health care services	\$ _____
Hair cuts/personal grooming	\$ _____
Clothing	\$ _____
Other	\$ _____
Total Monthly Non-Shelter Living Expenses	\$ _____

F. GIFTS

Have you made gifts in excess of \$1,000 in any one month, to an individual or group of individuals, within the past 60 months?

If yes, list below:

Recipient _____ Date _____ Amount _____

Recipient _____

Date _____ Amount _____

Recipient _____ Date _____

Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

If yes, please state details

G. CHILDREN (if applicable, include adult and minor children)

Name of Child _____ **Gender:** Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship: Natural child Adopted Stepchild

Name of Child _____ **Gender:** Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship: Natural child Adopted Stepchild

Name of Child _____ Gender: Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship: Natural child Adopted Stepchild

Name of Child _____ Gender: Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

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 your 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 children live with you in your home? Yes No

If yes, name of child _____

Does a sibling live in your home with you? Yes No

H. CONTACT PERSON

Name _____

K. CERTIFICATION

The undersigned hereby represents to Abrams Berger, P.A., and each of its attorneys that the information contained in this intake form is accurate and 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.

Signature of Client or Client Representative:

Date: _____

MEDICAID PLANNING - ADDITIONAL INFORMATION

A. ASSETS/LIABILITIES

ASSET	ASSET TOTAL	LIABILITY TOTAL
AUTOMOBILE (YEAR AND MODEL)		
CHECKING (PLEASE LIST BANKS)		
SAVINGS (PLEASE LIST BANKS)		
MONEY MARKET (PLEASE LIST INSTITUTION)		
CERTIFICATES OF DEPOSIT (PLEASE LIST INSTITUTION)		

RESIDENCE (FAIR MARKET VALUE)		
OTHER REAL ESTATE (FAIR MARKET VALUE)		
OTHER AUTOMOBILES		
BROKERAGE/CAP ACCOUNTS (PLEASE LIST INSTITUTIONS)		
MUTUAL FUNDS (PLEASE LIST INSTITUTIONS)		
STOCKS (PLEASE LIST WHERE HELD)		
BONDS (PLEASE LIST TYPE/WHERE HELD)		
ANNUITIES (PLEASE LIST WHERE HELD)		
LIFE INSURANCE-SEE BELOW		

TRADITIONAL IRA/RETIREMENT PLANS		
ROTH IRA		

NURSING HOME DEPOSIT PREPAID

FUNERAL OTHER: OTHER: TOTALS

What did you pay for your current home including any improvements?

\$ _____

Address of any real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____

What did you pay for this property including any improvements?

\$ _____

(2) Street _____ City _____ State _____ Zip _____

B. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost \$ _____

Monthly Prescription Cost \$ _____

Monthly Incontinent Cost \$ _____

Monthly Medical Insurance Cost (ill Spouse Only) \$ _____

Total Monthly Cost \$ _____

The nursing home is paid through

_____ (month/year).

C. LIFE INSURANCE

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 Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____

Beneficiary _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____