TERESA K. BOWMAN P.A.
Elder Law Planning and Advocacy

LONG -TERM CARE PLANNING QUESTIONNAIRE

Main Contact Person_____Date _____

Home Phone No._____ Business Phone No. _____

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

PERSONAL DATA

(Husband)

Full Legal Name_____

Known as_____

Birth Date_____

Social Security No._____

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

If so, when? _____

If deceased, date of death: _____

(Wife)

Full Legal Name _____

Known as _____

Birth Date _____

Social Security No. _____

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

If so, when? _____

If deceased, date of death:_____

Date of Current Marriage_____Number of prior marriages_____

Is there a prenuptial agreement in place?_____

Street Address _____

City_____ State_____Zip _____

Phone Numbers _____

Email_____Alternate Email_____

How do you prefer to be contacted:_____

Do you wish us to copy anyone else if we email you? Yes_____ No_____

If yes, provide email address_____

Do you currently have the following documents?

Wills_____ Date of execution_____

Powers of Attorney_____ Date of execution_____

Who is named as your agent for financial matters?_____

Health Care Directives_____ Date of execution_____

Who is named as your decision maker for health care?_____

Living Wills_____ Date of execution_____

Joint Trust_____ Date of execution_____
Individual Trust_____

Who is named as your successor Trustee?_____

Please bring copies of the above documents with you so we may review them at the time of the consultation. If you cannot make copies, bring originals and we will make copies.

A. HEALTH

Name of Ill Spouse _____

Diagnosis & Prognosis _____

Course of Treatment _____

Where Ill Spouse Currently Resides _____

Name of Well Spouse _____

Health of Well Spouse _____

Where Well Spouse Currently Resides _____

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis _____

Is either spouse suffering from any type of blindness? Yes☐ No ☐

Does either spouse need any assistance with the following (check all that apply):

Eating ☐ Bathing ☐ Dressing ☐ Toileting ☐Transferring ☐Maintaining Continence ☐

Does either spouse suffer from a mental disability (i.e. Alzheimer's, etc.)? Yes☐ No ☐

Is there a family history of mental disability? Yes☐ No ☐

Has either spouse suffered a stroke or been diagnosed with diabetes? Yes☐ No ☐

Is there longevity in either spouse's family? Yes☐ No ☐

Does either spouse still operate a motor vehicle? Yes☐ No ☐

B. PHYSICIAN & HEALTH INFORMATION

Full Name of Primary Physician _____

Address _____

C. INSURANCE

Are you currently on a Part D prescription plan? Yes☐ No ☐

Do you or your spouse have a Medicare Supplemental Insurance Policy? Yes☐ No ☐

Do you or your spouse have Long Term Care Insurance? Yes☐ No ☐

D. REAL ESTATE

Homestead: Address_____how long?_____

Is there any mortgage, line of credit or reverse mortgage? If so, how much? $_____

List all names that are currently on the title of the home. _____

_____

Address of any real property other the homestead:

Full Address: _____Vacation or Rental?_____

Full Address: _____ Vacation or Rental?_____

Are any of these properties owned by a Trust? Yes_____No_____If so, bring a copy of the trust.

Do you have any jointly owned property?_____

Do you maintain a home in another state that you live in part of the year?_____

Do you plan on selling any real property in the next few years?_____

E. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$_____	$_____
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.

Could this pension amount increase in the future? Yes ☐ No ☐

Estimate of all interest and dividend income: $_____

F. MONTHLY COST OF NURSING HOME OR ASSISTED LIVING FACILITY IF APPLICABLE

$_____	Monthly Nursing Home Cost
$_____	Monthly Assisted Living Cost
$_____	Monthly Prescription Cost
$_____	Monthly Level of Care Cost
$_____	Monthly Other Cost
$_____	**TOTAL MONTHLY COSTS**

The nursing home / assisted living is paid through_____(month/year).

G. MONTHLY SHELTER EXPENSES

(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**

H. MONTHLY NON-SHELTER LIVING EXPENSES

$_____	Food
$_____	Medical (including all pharmacy expenses)
$_____	Clothing
$_____	Transportation (including auto insurance)
$_____	Home Maintenance
$_____	Life Insurance Premiums
$_____	Health Insurance Premiums
$_____	Cable TV
$_____	Federal and State Income Taxes
$_____	Other
$_____	**Total Monthly Non-Shelter Living Expenses**

I. ASSETS/LIABILITIES

Please insert the approximate value of each asset/liability in the appropriate space. Please also notice the next page requesting additional details for your real estate, retirement accounts and life insurance.

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
RESIDENCE (CURRENT ASSESSED VALUE)				
OTHER REAL ESTATE (current value)				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
MUTUAL FUNDS				
STOCKS				
BONDS				
RETIREMENT ACCOUNTS (See details in Section J below)				
CASH VALUE – LIFE INSURANCE				
ANNUITIES				
CLOSELY HELD BUSINESS				
NURSING HOME DEPOSIT				
PERSONAL HOUSEHOLD GOODS				
AUTO MOBILES				
BOATS, CANOES, & TRAILERS				
ANY OTHER ASSETS, OR ASSETS IN A SAFE DEPOSIT BOX				
TOTALS				

J. RETIREMENT ACCOUNTS

Company Name	Type of Account (IRA, 401(K), etc.)	Current Value	Owner	Beneficiary (Primary & Secondary

K. LIFE INSURANCE

(Include the cash value of the life insurance on the Life Insurance line for the prior page)

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

Company Name	Type (Term, whole life, universal)	Death Benefit Value	Face Value	Cash Value	Owner	Insured	Beneficiary (Primary & Secondary)

L. GIFTS

Please list gifts made in any one month, to an individual or group of individuals, within the past 60 months:

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

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

If so, please state details _____

Have any children received an advance on their inheritance or are any children financially indebted to you?_____If so, please explain. _____

_____

Does anyone else owe you money? If so, please explain.

_____ _____

M. CHILDREN (if applicable)

Does the Husband have any children by a previous marriage? Yes ☐ No ☐

Does the Wife have any children by a previous marriage? Yes ☐ No ☐

Are all of your children in good health? Yes ☐ No ☐

Are any of your children blind or disabled? Yes ☐ No ☐

Are any of your children receiving SSI or other forms of government entitlement? Yes ☐ No ☐

Do any family members have trouble with their own finances? Yes ☐ No ☐

Do any of your children live with you in your home? Yes ☐ No ☐
If yes, name of child _____

CHILD'S NAME	ADDRESS (WITH ZIP CODE)	PHONE NUMBER	DATE OF BIRTH	Husband Wife / Both

N. FUNERAL/CEMETARY

Do you own cemetery lots?_____ If so, where? _____
Do you plan on burial or cremation? _____

Have you prepaid any funeral, cremation or burial expenses? _____

O. MISCELLANEOUS

Do you have any other legal issues that I should be aware of? Yes ☐ No ☐

If yes, please explain _____

_____

_____

P. REFERRAL

Who referred you to this office?

Name _____

Address _____

Q. CERTIFICATION

The undersigned hereby represents to Teresa K. Bowman, P.A., hat the information contained in this intake form is accurate and complete (to the best of your ability), and that the undersigned understands that the law firm will rely on this information. The undersigned also understands 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: _____

Once completed, please return this form to:

Teresa K. Bowman, P.A.
1800 2nd Street
Suite 735
Sarasota, FL 34236
941-735-5200