

**ELDER LAW
PLANNING QUESTIONNAIRE**

Date: _____ Home Phone: _____ Business Phone: _____

**PART A
PERSONAL INFORMATION**

CLIENT HUSBAND:

First Name Middle Name Last Name

Address: _____

U.S. Citizen: Yes No Birthdate: _____

Social Security Number: _____

CLIENT WIFE:

First Name Middle Name Last Name

Address: _____

U.S. Citizen: Yes No Birthdate: _____

Social Security Number: _____

CHILDREN:

Are any of your children blind? Yes No
Are any of your children disabled? Yes No
Do any of your children live with you in your home? Yes No

PART B
MEDICAL INFORMATION

Husband

Age of Husband: _____

If in a nursing home or contemplates entering a nursing home, please list the following:

Diagnosis: _____

Prognosis: _____

Course of Treatment: _____

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:

Nursing Home: _____ Date Entered: _____

Wife

Age of Wife: _____

If in a nursing home or contemplates entering a nursing home, please list the following:

Name of Spouse (in nursing home or to enter nursing home): _____

Diagnosis: _____

Prognosis: _____

Course of Treatment: _____

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:

Nursing Home: _____ Date Entered: _____

**PART C
MONTHLY INCOME**

	Husband's Monthly Income	Wife's Monthly Income
Gross Salary or Wages		
Social Security Benefits (before deducting Medicare Part B Payment, if applicable)		
Pension		
Pension		
Interest		
Dividends		
Other		

TOTAL INCOME:

For each pension, please list the gross pension amount and the name of the company or governmental entity paying the pension, and itemize all deductions from your check:

Payee: _____
 Gross Amount: \$ _____
 Govt Agency or Employer: _____
 Deductions: \$ _____

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 Gross Amount: \$ _____
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For Each Pension Check, also identify the amount that will still be payable to the survivor after the death of the payee.

**PART D
GIFTS**

(Gifts made in excess of \$5,100 (total to all recipients) in any month other than to your spouse within the past 36 months.)

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

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Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

Recipient: _____ Date: _____ Amount: _____

**PART E
ASSETS**

Please insert the approximate value of each asset/liability in the appropriate space:

ASSET	HUSBAND	WIFE	JOINT	LIABILITIES
Personal Effects				
Automobile				
Business Interest				
Checking Account				
Savings Account				
Money Market Account				
Savings Certificate				
Residence (assessed value)				
Additional Autos				
Other Real Estate				
Mutual Funds				
Stocks				
Bonds				
Annuities				
Cash Value - Life Ins. (include cash value)				
IRA				
Other				
Other				
Other				
TOTALS:				

What is the original cost basis for your personal residence? _____

The address of any real property other than personal residence:

Address: _____

Tax Block # _____ Lot # _____ (This can be obtained from tax bill.)

Address: _____

Tax Block # _____ Lot # _____ (This can be obtained from tax bill.)

Address: _____

Tax Block # _____ Lot # _____ (This can be obtained from tax bill.)

**PART F
LIFE INSURANCE**

COMPANY (include address & policy number)	TYPE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

NOTE: It is very important to know the cash value of your life insurance policy. (To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.)

PART G
MONTHL HOUSING EXPENSE

NOTE: Please divide annual expenses by 12 and quarterly expenses by 3 and semiannual by 2.

\$ _____	Mortgage
\$ _____	Rent
\$ _____	Taxes for Real Estate
\$ _____	Water & Sewer
\$ _____	Utilities (heat and electric (1/12 th of last 12 months))
\$ _____	Homeowner's Insurance Premium
\$ _____	Condominium Fees
\$ _____	MONTHLY TOTAL

PART H
MONTHLY COST OF NURSING HOME

\$ _____	Cost Per Month
\$ _____	Prescription Cost Per Month
\$ _____	Incontinent Cost Per Month
\$ _____	Other Per Month
\$ _____	MONTHLY TOTAL

PART I
MONTHLY NON-SHELTERED LIVING EXPENSES

\$ _____	Food
\$ _____	Medical
\$ _____	Clothing
\$ _____	Transportation
\$ _____	Home Maintenance
\$ _____	Life Insurance Premiums
\$ _____	Health Insurance Premiums
\$ _____	Cable TV
\$ _____	Other
\$ _____	MONTHLY TOTAL

**PART J
CHILDREN**

Name: _____ Date of Birth: _____

Address (with zip): _____ Telephone: _____

Name: _____ Date of Birth: _____

Address (with zip): _____ Telephone: _____

Name: _____ Date of Birth: _____

Address (with zip): _____ Telephone: _____

Name: _____ Date of Birth: _____

Address (with zip): _____ Telephone: _____

Name: _____ Date of Birth: _____

Address (with zip): _____ Telephone: _____

Order of priority for Children to serve as your Agent:

1. _____

2. _____

3. _____

Do you have a current power of attorney for financial matters: _____

Do you have a current power of attorney for health care: _____

Provide copy of current wills, powers of attorney, trusts, most recent bank statements, deeds, and last three years tax returns.