Weatherby & Associates, PC
Counselors at Law
Helping Families Preserve and Protect Assets and Values

LONG-TERM CARE PLANNING QUESTIONNAIRE

All information disclosed on this Questionnaire will be held in the strictest confidence and will not be disclosed to any third party without your consent.

If you are single and have received this form cross out either the reference to Husband or Wife and enter your personal information in the section you did not cross out.

Client

Full Legal Name_____ Nickname_____

Name on Legal Documents_____ SSN_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Birthdate_____

Email Address_____ Do you want to be an organ donor? ☐ Yes ☐ No

If not you, who is your "Contact Person" (the person we should contact for appointments, more information, etc.)?

Name_____ Phone Number_____

Are you a Veteran? ☐ Yes ☐ No Dates of Service _____ Branch of Service _____

If your significant other is deceased, what was the year of death? _____ US Citizen? ☐ Yes ☐ No

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference? ☐ Yes ☐ No If yes, what religion are you? _____

Spouse/SO

Full Legal Name_____ Nickname_____

Name on Legal Documents_____ SSN_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Birthdate_____

Email Address_____ Do you want to be an organ donor? ☐ Yes ☐ No

If not you, who is your "Contact Person" (the person we should contact for appointments, more information, etc.)?

Name_____ Phone Number_____

Are you a Veteran? ☐ Yes ☐ No Dates of Service _____ Branch of Service _____

If your significant other is deceased, what was the year of death? _____ US Citizen? ☐ Yes ☐ No

When health care decisions must be made on your behalf, do you want your agent to take into account your religious preference? ☐ Yes ☐ No If yes, what religion are you? _____

Personal Information Continued:

Have you ever lived in any of the following states: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin? ☐ Yes ☐ No

Client: Are either of your parents still living? ☐ Yes ☐ No Are either of your grandparents still living? ☐ Yes ☐ No

Spouse: Are either of your parents still living? ☐ Yes ☐ No Are either of your grandparents still living? ☐ Yes ☐ No

Are you currently employed, if so please complete the following:

Employer_____ Position_____

Address_____ City_____ State_____ Zip_____

Business Phone _____ Business Fax_____

Is your Spouse/SO currently employed, if so please complete the following:

Employer_____ Position_____

Address_____ City_____ State_____ Zip_____

Business Phone_____ Business Fax_____

Please check which documents you and your Spouse/SO currently have established in the chart below.

	Client	Spouse/SP	Both
Durable Power of Attorney			
Health Care Power of Attorney			
Living Will			
Will			
Revocable Living Trust			
Advanced Designation of Conservator			

Please provide us with a *copy* of each document.

Do you or your Spouse/SO have any dependents (that is, someone who depends on you, in whole or in part, for their support)? ☐ Yes ☐ No If yes, who?: _____

MARITAL INFORMATION

Date of Current Marriage_____ Existing Prenuptial Agreement?_____

Place of Marriage
(City, State, Country): _____

If either significant other has been married before, please provide the date and place of divorce, if applicable:

Client:

Name of Former Spouse/SO: _____

Date of Marriage	Place of Marriage	Year Terminated

Spouse/SO:

Name of Former Spouse/SO: _____

Date of Marriage	Place of Marriage	Year Terminated

If a former Spouse/SO is still alive, please list the name of, and describe the relationship with the former Spouse/SO:

_____

_____

_____

About Your Family

Children	**1**	**2**	**3**
Name:	_____	_____	_____
Child of (circle):	☐H ☐JT ☐W	☐H ☐JT ☐W	☐H ☐JT ☐W
Birth Date:	_____	_____	_____
Phone Number:	_____	_____	_____
Email Address:	_____	_____	_____
Address:	_____	_____	_____
City, State Zip:	_____	_____	_____
Occupation:	_____	_____	_____
Married?:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
How many times?:	_____	_____	_____
If married, to whom?:	_____	_____	_____
How long married?:	_____	_____	_____
Is marriage stable?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Significant Other's Occupation:	_____	_____	_____
Does child manage money well?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Positive relationship with siblings:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Positive relationship with parents:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Grandchildren:			
Name	_____	_____	_____
Birth Date	_____	_____	_____
Name	_____	_____	_____
Birth Date	_____	_____	_____
Name	_____	_____	_____
Birth Date	_____	_____	_____
Does grandchild manage money well?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Positive relationship with siblings:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Positive relationship with parents:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Other Comments: _____

_____

_____

Children (Con't)

	4	5	6
Name:			
Child of (circle):	☐H ☐JT ☐W	☐H ☐JT ☐W	☐H ☐JT ☐W
Birth Date:	_____	_____	_____
Phone Number:	_____	_____	_____
Email Address:	_____	_____	_____
Address:	_____	_____	_____
City, State Zip:	_____	_____	_____
Occupation:	_____	_____	_____
Married?:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
How many times?:	_____	_____	_____
If married, to whom?:	_____	_____	_____
How long married?:	_____	_____	_____
Is marriage stable?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Significant Other's Occupation:	_____	_____	_____
Does child manage money well?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Relationship with siblings:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Relationship with parents:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Grandchildren:

Name	_____	_____	_____
Birth Date	_____	_____	_____
Name	_____	_____	_____
Birth Date	_____	_____	_____
Name	_____	_____	_____
Birth Date	_____	_____	_____
Does grandchild manage money well?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Positive relationship with siblings:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Positive relationship with parents:	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Other Comments: _____

_____

_____

UNAVAILABLE CHILD(REN)

If the individual needing care has children, and any child(ren) are not to be relied upon for any reason to help with management or other needs of parent(s), please list name of such child(ren) and provide a short explanation why you believe such is the case:

_____

_____

_____

_____

Other thoughts/comments? _____

_____

_____

Siblings

How many siblings? _____ _____

Where are you in the order? _____ _____

Are any of your children receiving Supplement Security Income, Social Security Disabiliy; or, in not has any major disabilities? ☐ Yes ☐ No If yes, who? _____

ADVISORS' CONTACT INFORMATION

Accountant _____ Phone _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Financial Advisor _____ Phone _____

Address _____ City _____ State _____ Zip _____

E-mail _____

Insurance Agent _____ Phone _____

Address: _____ City _____ State _____ Zip _____

E-mail: _____

Referred to Our Firm By _____

Health-Related Problems

Client

Current Health Problems:

_____

_____

Past Health Problems:

_____

_____

Please list all of the medication you are currently taking:

Medication	Why are you taking this drug?
_____	_____
_____	_____
_____	_____
_____	_____

Does your family have any history of health problems? ☐ Yes ☐ No If so, please explain_____

_____

Tell us about your parents (if applicable):

	Your Mother	Your Father
Age of Death:		
Cause of Death:		

Your Personal Physician(s): _____Phone_____

Address:_____ City _____State _____ Zip_____

E-mail: _____

Spouse/SO

Current Health Problems:

_____

_____

Past Health Problems:

_____

_____

Please list all of the medication you are currently taking:

Medication	Why are you taking this drug?

Does your family have any history of health problems? ☐ Yes ☐ No If so, please explain_____

_____

Tell us about your parents (if applicable):

	Your Mother	Your Father
Age of Death:		
Cause of Death:		

Your Personal Physician(s): _____Phone_____

Address:_____ City _____State _____ Zip_____

E-mail: _____

CAPACITY

Are there any known problems with the individual's memory or understanding?

Client: Yes ____ No ____

Spouse/SO: Yes ____ No ____

If you answered yes, please describe the nature of the problem:

_____

_____

_____

_____

_____

Please indicate Yes or No to the following questions:	Client	Spouse/SO
Is the individual able to sign his or her name?		
Able to speak?		
Able to recognize family members and acquaintances?		
Cognizant of his or her property and personal possessions?		
Able to travel outside his or her current place of residence?		

Residence - Owned

A. Owner(s): _____

B. How is the title held? _____

PLEASE PROVIDE US WITH A COPY OF THE DEED AND MOST RECENT TAX BILL.

C. Fair Market Value? $ _____

D. Outstanding Mortgage (list amount): $ _____

If so, is it a Reverse Annuity Mortgage (RAM)? Yes ____ No ____

Basic terms: _____

E. Single family residence? Yes ____ No ____

F. If the property was purchased, please provide the following:

1. Number of units: _____
2. Currently being rented? Yes ____ No ____
3. Are tenants under lease? Yes ____ No ____

G. If the property was purchased, please provide the following:

1. Date of Purchase: _____
2. Purchase price: $ _____

H. If the property was inherited, please provide the following:

1. Month/year of Inheritance _____
2. Value on date of inheritance (if available): $ _____

I. If improvements have been made to the property, please detail the value and nature of the improvements:

_____

_____

_____

J. Has (have) the owner(s) used the principal residence capital gains tax exclusion? Yes ____ No ____

K. If at least one occupant of the residence is a child of the individual need in long-term care, has that child lived in the residence for at least two (2) years? Yes ____ No ____

1. Has the child provided personal care to the parent(s) that might have delayed the need for long-term care for the parent(s)? Yes ____ No ____

2. If yes, please describe the nature and duration of the care provided:

_____

_____

_____

L. Do the individual(s) needing care have any living children who are disabled? Yes ____ No ____

If yes, please describe the nature of the disability:

_____

_____

_____

M. If the owner has a brother or sister, has the brother or sister lived in the house for at least one (1) year? Yes ____ No ____

If yes, does the sibling still reside in the home? Yes ____ No ____

Residence - Rented

Monthly Cost: $_____

Type of rental: Single Family ____ Apartment ____

Residential Care ____ Life Care ____

Senior Housing ____

Is there a rental or lease agreement? Yes ____ No ____

Is the rent being subsidized? Yes ____ No ____

If so, by whom and for how much?_____ $_____

Long-Term Care (LTC)

	Client	Spouse/SO
Is the individual(s) currently receiving long-term care? *(please indicate yes or no)*		
If so, what was the date of entry into the nursing home or facility, or the date the home care was started?		
Name of the LTC facility/provider:		
Address:		
Business Telephone:		
Administrator or other contact:		

Hospital

	Client	Spouse/SO
Is either individual currently in a hospital? *(please indicate yes or no)*		
Name/Location of the Hospital:		
Date admitted:		

Please list the current duration of the hospital stay, and a brief description of the medical problem:

	Client	Spouse/SO
Is placement in a LTC facility expected? *(please indicate yes or no)*		
If placement is expected, is it likely that he or she will return home?		

INCOME INFORMATION

Please enter your current **monthly** income in the "Self" column below. Enter your spouse's income in the "Spouse" column. If any income is received jointly in both names, enter it in the "Joint" column. Enter the income of any others living in the household in the "Household" column.

Please Note: Estimate or guess if exact income numbers are not readily available. It is not necessary to fill in all boxes for the questionnaire to work. Don't worry if all answers are not known, just fill in the information available now and proceed to the next page.

Types of Monthly Income:	**Client**	**Spouse/SO**	**Joint**	**Household**
Pension/Retirement Benefits				
Dividends/Interest				

Types of Monthly Income:	**Client**	**Spouse/SO**	**Joint**	**Household**
Supplemental Security Income				
Social Security Disability				
Social Security Retirement/Survivor Benefits				
Railroad Retirements Benefits				
Veteran's Benefits				
Worker's Compensation				
Cash Assistance				
Other Non-Work Income				

Assets/Resources

The values listed are for discussion purposes only. A more accurate list will be obtained at a later dated.
You may use the back of this paper to continue a list in each category of asset.

To identify the Owner of an asset, use "JTS" for joint ownership with Spouse/SO; "JTO" for joint ownership with non-Spouse/SO; "H" for Husband as sole owner; "W" for Wife as sole owner; or "T" if owned by a revocable trust that you have created.

Bank and Savings Accounts. To identify type of account, use "CA" for checking account; "SA" for savings account; "CD" for certificate of deposit; "MM" for money market account. *Do not include IRAs or 401(k)s here*.

	Financial Institution	Owner	Market Value	Type of Account
Bank and Savings Accounts	1.			
	2.			
	3.			
	4.			
	5.			

Stocks, Bonds or Investment Accounts. List any and all stocks and bonds you own. If held in a brokerage account, lump them together under each account. *Do not include IRAs or 401(k)*s.

	Stock, Bond or Investment Acct	Owner	Market Value	Type of Plan
Stocks and Bonds	1.			
	2.			
	3.			
	4.			
	5.			

Retirement Accounts. To identify type of account, use "P" for pension; "PS" for profit sharing; IRA, Roth IRA, SEP, or 401(k).

	Custodial Institution	Owner	Market Value	Type of Plan
Retirement Accounts	1.			
	2.			
	3.			
	4.			
	5.			

Real Estate.

	Description	Owner	Market Value	Debt
Real Estate	1.			
	2.			
	3.			
	4.			
	5.			
	6.			

Personal Property.

	Description	Owner	Market Value	Debt
Personal Property	1. Autos			
	2. Auto			
	3. Household Contents			
	4.			
	5.			

If this is your only vehicle, enter the Blue Book value of your vehicle. If you have more than one vehicle, enter the Blue Book value of most valuable vehicle. If you don't know the Blue Book value of your car, you may visit this web site to find out. http://www.kbb.com

You should also feel free to estimate, if necessary.

Life Insurance Policies and Annuities. List the issuing company. To identify type of contract, use "T" for term insurance, "CV" for insurance policies having a cash value, "A" for annuities.

	Insurance Company	Type	Owner	Insured	Cash Value	Death Benefit
Life Insurance/ Annuities	1.					
	2.					
	3.					
	4.					
	5.					

Other Property. List other property that you have that does not fit into any other listed category. This may include an interest in a closely-held business, monies owed to you, etc.

	Description	Owner	Market Value
Other Property	1.		
	2.		
	3.		
	4.		
	5.		

Additional Documentation

General Document Requests.

Please keep in mind that terms and agreements within these documents which may be applicable to you may affect the reasonable estimate we obtain of benefit amounts for which you may qualify. If applicable, assets and income from these must also be listed

- Long-term care policies (if any).
- Divorce Decree or Property Settlement Agreement for divorce under which continued obligations exist.
- Promissory Notes documenting money loaned to the family members

EXEMPT RESOURCES

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the individual needing care has the listed items: (please indicate yes or no)

	Client	Spouse/SO
Burial plot: ***(please provide a copy of deed)***	_____	_____
Irrevocable burial fund contract: ***(please provide a copy)***	_____	_____

Who now has "assistance" responsibilities (i.e., are any family member or other individuals providing custodial or other types of care to the individual needing assistance)? Please list name, phone number, and relationship to the person receiving the care:

For Client: _____

For Spouse/SO: _____

HEALTH AND LTC INSURANCE

(Use back of form if necessary)

If either and/or both individual(s) have Medicare Parts A, B and/or D, private health or long-term care insurance, or are paying for a Medicare supplement policy, please provide the following information:

Name of Insurer and Policy #	Type of Policy	Monthly Premium	If LTC Insurance Daily Benefit
_____			
#		$	$
_____			
#		$	$
_____			
#		$	$
_____			
#		$	$

PUBLIC BENEFITS AND COMMUNITY SERVICES

In addition to Social Security and Medicare, are you receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, ConnPace, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group services, property tax relief, home weatherization, and drug company discount card programs. ☐ Yes ☐ No

If yes, please list them below:

Provider	Form of Assistance
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Transfers Within 60 Months

Have you made any gifts or transfers, greater than **$500.00**, to any individuals or to a trust within the last 60 months (five years)? ☐ Yes ☐ No

If yes, please furnish the indicated information for each gift or transfer:

To Whom:	_____	To Whom:	_____
Date of Gift:	_____	Date of Gift:	_____
Item:	_____	Item:	_____
Value:	_____	Value:	_____
To Whom:	_____	To Whom:	_____
Date of Gift:	_____	Date of Gift:	_____
Item:	_____	Item:	_____
Value:	_____	Value:	_____

If gift tax returns were filed on any of the gifts listed above (if applicable) please provide copies.

Transfers To Or From Trusts

Has the individual(s) transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past sixty (60) months?

Client: Yes ____ No ____

Spouse/SO: Yes ____ No ____

If so, please provide the following information:

Name of Trust	Amount	Date
_____	$ _____	_____
_____	$ _____	_____
_____	$ _____	_____

MONTHLY EXPENSES

Item	Amount Client	Spouse/SO	Joint
Property Tax	$_____	$_____	$_____
Home maintenance and upkeep	$_____	$_____	$_____
Homeowners insurance	$_____	$_____	$_____
Utilities (gas, electric, water & sewer, security)	$_____	$_____	$_____
Residential facility	$_____	$_____	$_____
Private health care services	$_____	$_____	$_____
Telephone	$_____	$_____	$_____
Cable television	$_____	$_____	$_____
Auto operation (gas and maintenance)	$_____	$_____	$_____
Clothing	$_____	$_____	$_____
Groceries and other household	$_____	$_____	$_____
Hair cuts, personal grooming	$_____	$_____	$_____
Laundry and cleaning	$_____	$_____	$_____
Check account charges/bank fees	$_____	$_____	$_____
Newspapers and magazines	$_____	$_____	$_____
Recreation, vacation, entertainment	$_____	$_____	$_____
Health insurance (such as Medicare supplement)	$_____	$_____	$_____
Unreimbursed medical expense (such as for drugs)	$_____	$_____	$_____
Life Insurance	$_____	$_____	$_____
Charitable contributions	$_____	$_____	$_____
Other:	$_____	$_____	$_____
_____			
Other:	$_____	$_____	$_____
_____			
Total Monthly Expenses:	$_____	$_____	$_____

Is the senior citizen real property tax exemption being used? ☐ Yes ☐ No

Is the veteran's real property tax exemption being used? ☐ Yes ☐ No

FUNCTIONAL LIMITATIONS AND SUPPORT

The term "activities of daily living" refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help in order to cope, from either other human beings or mechanical devices (such as a walker or wheelchair) or both.

Why do we want this information? Measurement of the activities of daily living is critical because the more assistance people need with their daily activities the more likely are they to be admitted to a nursing home or other living arrangement: to use paid home care; to use hospitals and doctors; and to die sooner rather than later.

Place an X in the box that most applies for each activity.

Activities of Daily Living	Client			Spouse		
Activity	Need No Help	Need Some Help	Unable to Do at All	Need No Help	Need Some Help	Unable to Do at All
Bathing						
Dressing						
Transferring from bed to chair						
Walking						
Feeding Self						
Using the toilet						
Grooming						
Using the telephone						
Getting out by car or public transport						
Grocery shopping						
Preparing meals						
Doing housework or handyman work						
Doing laundry						
Managing and Taking medications						
Managing money						

List the names of all persons who provide assistance or care giving for each of you:_____

_____

_____

Planning Concerns & Anxieties

Successors

If you were incapacitated for any period of time, who would you choose to handle your financial affairs?

		Clients Response	Spouse/SO Response
Financial Successor	First Choice		
	Second Choice		

If you were (both) incapacitated for any period of time, who would you choose to make health care decisions for you?

		Clients Response	Spouse/SO Response
Health Care Successor	First Choice		
	Second Choice		

Planning for the Distribution of Your Assets

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations. **Please note that we expect that this will be completed during our first conference with you regarding estate planning. You may want to use this section as items to consider before our conference.**

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, Spouse/SO of child, etc.)

1. Client #1: _____

Does Spouse/SO survive you? Yes ____ No ____

If Spouse/SO does not survive you:

_____

_____

If neither Spouse/SO, nor children survive you:

_____

_____

2. Client #2: _____

Does Spouse/SO survive you? Yes ____ No ____

If Spouse/SO does not survive you:

If neither Spouse/SO nor children survive you:

3. Any specific disposition of your residence?

Client #1:

Client #2:

4. Any specific gifts of special articles, such as art or jewelry?

Client #1:

Client #2:

5. Household and personal effects:

Client #1: _____

Client #2: _____

Include here any information that you think is important to your estate planning.

***Statement of goals*: _____**