TPC

The Peninsula Center

for Estate and Lifelong Planning
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LONG-TERM CARE PLANNING WORKSHEET

The purpose of an initial consultation is for the attorney to advise you, the *prospective* client, what, if anything, may be done for you, and what the fee therefore will be. ***The purpose is not to render a definitive legal opinion*** as it may be impossible to fully assess a matter within the time frame allotted for a consultation or with the information or documents that you may be able to provide at the initial consultation.

A. **You and the Attorney mutually agree to the terms of representation** (After a separate document called a Retainer Agreement is signed, a copy will be provided to you); **or**
B. **The Attorney declines representation, or**
C. **You decide not to use the services of the Attorney.**

Note: **The following information will help us to understand your situation and what your goals and objectives are. We request you complete this form and bring it with you to your consultation appointment as having this information is crucial to a successful and productive meeting. Whether or not you hire our firm to represent you, your responses are protected by the attorney/client privilege and will be held in strict confidence.**

PART I: General Information

Client 1

Name: _____ Date of Birth: _____

Social Security Number: _____ U.S. Citizen: Y N (circle)

Occupation: _____ Veteran: Y N (circle)

Address: _____ Email:_____

City: _____ State: _____ Zip:_____

Phone No. _____(home) _____(work) _____(cell)

County of Residence (if any) :_____

(circle one) Married / Divorced / Widowed

Client 2 (if applicable)

Name: _____ Date of Birth: _____

Social Security Number: _____ U.S. Citizen: Y N (circle)

Occupation: _____ Veteran: Y N (circle)

Phone No. _____(work) _____(cell)

PART II: Children

Name	Date of Birth	Address	Marital Status	# of children
1) _____	_____	_____ _____	_____	_____
2) _____	_____	_____ _____	_____	_____
3) _____	_____	_____ _____	_____	_____
4) _____	_____	_____ _____	_____	_____

PART III: Health & Special Circumstances

Are there any known problems with memory or understanding?

Client 1: [ ] Yes [ ] No

Client 2: [ ] Yes [ ] No

If yes, please explain: _____

_____

Are Clients:	**Client 1**	**Client 2**
Able to sign name?	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to speak?	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to recognize friends & family?	[ ] Yes [ ] No	[ ] Yes [ ] No
Aware of property & possessions?	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to leave current residence?	[ ] Yes [ ] No	[ ] Yes [ ] No
Is help required?	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to drive?	[ ] Yes [ ] No	[ ] Yes [ ] No

Is any other family member living with Client(s) now? [ ] Yes [ ] No

Does either Client currently receive Medicaid, SSI, SSDI, or any other form of governmental assistance? [ ] Yes [ ] No [ ] Yes [ ] No

*If yes, explain:*_____

_____

Does either Client have long-term care insurance? [ ] Yes [ ] No

If so, please list basic details of coverage (who is covered, term of coverage in years, daily benefit): _____

_____

Physician (please provide name, address and phone number):

Client 1	**Client 2**
_____	_____
_____	_____
_____	_____

Health Insurance:	**Client 1**	**Client 2**
Primary		
Name of Carrier:	_____	_____
Subscriber:	_____	_____
Policy No:	_____	_____
Group No:	_____	_____
Secondary		
Name of Carrier:	_____	_____
Subscriber:	_____	_____
Policy No:	_____	_____
Group No:	_____	_____

Long Term Care (LTC):

Client 1

Currently Receiving LTC? [ ] Yes [ ] No
If so, date started: _____
Name of Facility/Provider: _____
Address: _____
Business Phone: _____
Administrator or Contact: _____

Client 2

Currently Receiving LTC? [ ] Yes [ ] No
If so, date started: _____
Name of Facility/Provider: _____
Address: _____
Business Phone: _____
Administrator or Contact: _____

Hospital:	**Client 1**	**Client 2**
Currently in Hospital?	[ ] Yes [ ] No	[ ] Yes [ ] No
If so, date admitted:	_____	_____
Name/location of hospital:	_____	
Description of medical issue:	_____	
Is LTC placement expected?	[ ] Yes [ ] No	[ ] Yes [ ] No
If so, likely to return home?	[ ] Yes [ ] No	[ ] Yes [ ] No

PART IV: **Assets** *(Please use another sheet if necessary– all information MUST be provided)*

Type of Asset *(List by Institution)*	**Account Number(s)** *(provide copies of statements for past 6 mos)*	**Owned by Client 1 or Trust (value)**	**Owned by Client 2 or Trust (value)**	**Jointly Owned (or joint trust) (value)**
Checking Accounts: 1. 2. 3.				
Savings Accounts: 1. 2. 3.				
CD's, Mutual Funds: 1. 2. 3.				
(Continued on next page)				

Annuities, Stocks, Bonds: 1. 2. 3.				
Personal Residence				
Other Real Estate				
Other Assets 1. 2. 3.				
TOTAL:				

Life Insurance:

Owner	**Beneficiary**	**Company/ Policy #**	**Type*** **(see below)**	**Cash Value**	**Death Benefit**

***P=Permanent; U=Universal; T=Term; G=Group**

Retirement Plan Assets (IRA's, 401K's, Deferred Annuities, etc.):

Participant/ Owner	**Beneficiary**	**Company/Acct #**	**Type***	**Value**

*Type = IRA, 401K, 403b, TSP, Deferred Annuity, or other qualified retirement plan

Additional Detail Needed:

<u>Residence</u> (*please provide copies of the deed and most recent tax bill*):

Primary Residence located at: _____

- Owners: Client 1 / Client 2 / Joint / Rented
- How is title held? _____
- How long has Client(s) lived in the home: _____
- Fair Market Value: $_____ (if owned)
- Mortgage Balance: $_____ (if owned)
  - Is it a Reverse Annuity Mortgage (RAM)? [ ] Yes [ ] No
  - Basic Mortgage Terms: _____
- Single Family Residence? [ ] Yes [ ] No
- If the property was purchased, please provide the following:
  1. Month/Year purchased: _____
  2. Purchase price: $_____
- If the property was <u>inherited</u>, please provide the following:
  1. Month/Year Inherited: _____
  2. Value when Inherited: $_____

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

_____

_____

- Has a child of either Client lived in the residence for at least 2 years? [ ] Yes [ ] No
  - If yes, has the child provided care to the parent that might have delayed the parent's need for long-term care? [ ] Yes [ ] No
  - If so, please describe the nature and duration of the care provided:

_____

_____

- Does either Client have any living child who is disabled? [ ] Yes [ ] No
  - If yes, please describe the nature of the disability:

_____

_____

- Does either Client have a sibling who has lived in the home for at least 1 year? [ ] Yes [ ] No
- If yes, does the sibling still reside in the home? [ ] Yes [ ] No

- If the property is rental property, please provide the following:
    1. Monthly Rent: $_____
    2. Type of Rental: [ ] Single Family [ ] Apartment
       [ ] Residential Care [ ] Life Care [ ] Senior Housing
- Is there a rental/lease agreement in place? [ ] Yes [ ] No
- Is the rent subsidized? [ ] Yes [ ] No
    - If so, by whom and amount?_____

Rental Property (*please provide copies of the deed and most recent tax bill):*

- Owners: Client 1 / Client 2 / Joint
- Monthly Rent: $_____
- Type of Rental: [ ] Single Family [ ] Multi-Family [ ] Apartment
- Is there a rental/lease agreement in place? [ ] Yes [ ] No
- Is the rent subsidized? [ ] Yes [ ] No
    - If so, by whom and amount?_____

Securities (stocks, bonds, marketable securities):

Name of Company	Type	# Shares/Face Val.	Basis	How Titled
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Personal Property *(please provide copies of most recent tax bills):*

	Market Value	How Title Held
Home Furnishings:	$_____	_____
Cars, RVs, Boats, etc.:	$_____	_____
Jewels, Furs, etc.:	$_____	_____
Other: collectibles, etc.		
_____	$_____	_____
_____	$_____	_____

Business Interests:
If either Client has any business interests, please provide a short description giving the name, location, percentage owned, and the form of ownership (i.e., sole proprietorship, C-corporation, S-corporation, limited liability company, general or limited partnership, etc.). ***Please bring a copy of any agreements, financial statements, etc. for all entities in which either client holds an interest.***

_____

_____

Rights or Interests in Trusts, Estates, or Prospective Inheritances:
Briefly give the name of the Trust or Estate in which either Client has an interest. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy. _____

_____

PART V: Gross Income Per *Month*

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment vehicle is the "owner" of the income.

Sources of Income (***Provide detail***)	**Client 1**	**Client 2**
Social Security 1. 2.		
Military or Civil Service Pension 1. 2.		
Other Retirement / Pension 1. 2.		
VA Disability Benefits:		
IRA / Retirement Plan Distributions:		
Investment Income		
Annuity Distributions		
Other Income 1. 2.		
TOTAL:		

PART VI: Debt

Sources of Debt ***(Please List)***	**Client 1**	**Client 2**
1.		
2.		
3.		
4.		

PART VII: Monthly Expenses

Expense ***(please list)***	**Client 1**	**Client 2**
Nursing Home Costs		
Prescription Medications		
Rent/Mortgage		
Utilities		
Food & Personal/Household Items		
Homeowners' Insurance		
Real Estate Taxes		
Condo or Homeowners' Association Dues		
Insurance *(describe; use separate sheet if necessary)*: 1. Health Insurance - 2. LTC Insurance - 3. Life Insurance -		
Unreimbursed Medical Expenses *(describe; use separate sheet if necessary)*: 1. Prescription Meds - 2. Physician Co-pays - 3. Medical Supplies (i.e. Depends) -		

PART VIII: Estate Planning Documents

(Please provide a copy of each document)

	Client 1	Client 2
Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No	[ ] Yes [ ] No
Pour-Over Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Health Care Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Living Will:	[ ] Yes [ ] No	[ ] Yes [ ] No

Other (list):	Client 1	Client 2
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART IX: Miscellaneous

Have you made any gifts or transfers for less than fair market value to any person within the past 60 months? YES / NO

Recipient_____ Date_____ Amount_____
Recipient_____ Date_____ Amount_____
Recipient_____ Date_____ Amount_____
Recipient_____ Date_____ Amount_____

Have you ever filed a federal gift tax return: _____

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 person needing care has the listed items.

	Client 1	Client 2
Burial plot:	[ ] Yes [ ] No	[ ] Yes [ ] No
Irrevocable burial contract:	[ ] Yes [ ] No	[ ] Yes [ ] No
Burial Fund or Savings Account	[ ] Yes [ ] No	[ ] Yes [ ] No

Client Goals

What are your goals? _____

_____

CERTIFICATION

The undersigned hereby represents that the information contained herein is accurate. The undersigned understands that the Law Firm will rely on the information presented on this form as well as information otherwise disclosed to the attorney in establishing an appropriate long-term care plan. If any information contained on this form or disclosed to the attorney is inaccurate or incomplete, the recommendations of the Law Firm may not be appropriate.

_____ _____

Client 1 Client 2

OR

_____

Client representative or Agent

Date Completed:_____