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LONG TERM CARE – MARRIED

Your appointment with this office is: _____ at _____

These questions pertain to the persons for whom we are planning. We ask a lot of questions on this form because we need a lot of information about you and your spouse for our planning for you. Do your best, but don't worry if some of the information you need to complete this form is not available to you. Please call us at if you have any questions or concerns about completing this form.

Date: _____ Referred by: _____

1. PERSONAL INFORMATION

Form with columns for HUSBAND and WIFE. Fields include: Name (First, Middle, Last), Name you prefer to be called, Date of Birth, SSN, Medicare Number, US Citizen?, Veteran?, Husband Home Address, City, State, Zip, Wife Home Address, City, State, Zip, County of Residence, Home Phone, Cell Phone, Home Email.

Name/Relationship:

Contact Information (if not you, who should we contact for appointments, information, etc.):

Phone:

Address:

2. CHILDREN:

1) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Both by birth/adoption <input type="checkbox"/> Husband's by birth/adoption <input type="checkbox"/> Wife's child by birth/adoption <input type="checkbox"/> Child taken into home (not yours by birth/adoption)
Child's Phone:		# Of Children

2) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Both by birth/adoption <input type="checkbox"/> Husband's by birth/adoption <input type="checkbox"/> Wife's child by birth/adoption <input type="checkbox"/> Child taken into home (not yours by birth/adoption)
Child's Phone:		# Of Children

3) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Both by birth/adoption <input type="checkbox"/> Husband's by birth/adoption <input type="checkbox"/> Wife's child by birth/adoption <input type="checkbox"/> Child taken into home (not yours by birth/adoption)
Child's Phone:		# Of Children

4) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Both by birth/adoption <input type="checkbox"/> Husband's by birth/adoption <input type="checkbox"/> Wife's child by birth/adoption <input type="checkbox"/> Child taken into home (not yours by birth/adoption)
Child's Phone:		# Of Children

5) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Both by birth/adoption <input type="checkbox"/> Husband's by birth/adoption <input type="checkbox"/> Wife's child by birth/adoption <input type="checkbox"/> Child taken into home (not yours by birth/adoption)
Child's Phone:		# Of Children

6) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Deceased	<input type="checkbox"/> Both by birth/adoption <input type="checkbox"/> Husband's by birth/adoption <input type="checkbox"/> Wife's child by birth/adoption <input type="checkbox"/> Child taken into home (not yours by birth/adoption)
Child's Phone:		# Of Children

Do you have any dependents (that is someone who depends on you, in whole or in part, for their support)? Yes No – If yes, who?

Are any of your children receiving Supplemental Security Income, Social Security Disability, or, if not, has any major disabilities?

Yes No

If yes, who?

3. LIVING ARRANGEMENTS

HUSBAND:

Place Where You Live		Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Nursing home FACILITY:	DATE OF ADMISSION:
<input type="checkbox"/>	Other:	

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

WIFE:

Place Where You Live		Since When?
<input type="checkbox"/>	Single-family home	
<input type="checkbox"/>	Same, but someone assists you there with above activities	
<input type="checkbox"/>	Apartment or retirement living community	
<input type="checkbox"/>	Assisted-living facility	
<input type="checkbox"/>	Nursing home FACILITY:	DATE OF ADMISSION:
<input type="checkbox"/>	Other:	

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

4. RESOURCES:

Monthly Income

(Do not list interest or dividend income)

SOURCE (gross income)	HUSBAND	WIFE	OTHER
Social Security:	\$	\$	\$
Pension:	\$	\$	\$
Other:	\$	\$	\$
TOTAL:	\$	\$	\$

Personal Residence

Address of Property:			
Names as they appear on deed:			
Date Acquired:		Purchase Price:	\$
Mortgage Company:			
Mortgage Balance:	\$	Tax-Appraised Value:	\$
Current Value:	\$		

Other Real Estate

Address of Property:			
Names as they appear on deed:			
Date Acquired:		Purchase Price:	\$
Mortgage Company:			
Mortgage Balance:	\$	Tax-Appraised Value:	\$
Current Value:	\$		

Address of Property:			
Names as they appear on deed:			
Date Acquired:		Purchase Price:	\$
Mortgage Company:			
Mortgage Balance:	\$	Tax-Appraised Value:	\$
Current Value:	\$		

Vehicles

Year, Make Model:	
Name(s) as they appear on title:	
Value:	

Year, Make Model:	
Name(s) as they appear on title:	
Value:	

Other Assets

These are your bank accounts, CDs, annuities, stocks, retirement plans, and the like.

Type of Asset:	
Name of Company:	
Value:	\$
How is it titled?:	

Type of Asset:	
Name of Company:	
Value:	\$
How is it titled:	

Type of Asset:	
Name of Company:	
Value:	\$
How is it titled:	

Type of Asset:	
Name of Company:	
Value:	\$
How is it titled:	

Type of Asset:	
Name of Company:	
Value:	\$
How is it titled:	

Type of Asset:	
Name of Company:	
Value:	\$
How is it titled:	

Type of Asset:	
Name of Company:	
Value:	\$
How is it titled:	

Life Insurance

Company Name:	
Owner:	
Insured:	
Beneficiary:	
Death Benefit (Face Value):	\$
Cash Surrender Value:	\$
Loan Against Policy (if any):	\$

Company Name:	
Owner:	
Insured:	
Beneficiary:	
Death Benefit (Face Value):	\$
Cash Surrender Value:	\$
Loan Against Policy (if any):	\$

Company Name:	
Owner:	
Insured:	
Beneficiary:	
Death Benefit (Face Value):	\$
Cash Surrender Value:	\$
Loan Against Policy (if any):	\$

Other Insurance:

Please complete the following health insurance information as it applies to both of you.

HUSBAND:

MEDICARE

Traditional Medicare Fee-For-Service Yes No

Or

Medicare HMO, PSO, PPO, or Private Pay Plan Yes No

Company:

Premium: \$ PAID: Monthly Quarterly Yearly

Medicare Supplement (“Medigap”) Yes No

Company:

Type (Plan A through J):

Premium: \$ PAID: Monthly Quarterly Yearly

Medicare Prescription Drug Plan Yes No

Company:

Premium: \$ Paid: Monthly Quarterly Yearly

Employer Retiree Health Plan Yes No

Company:

Premium: \$ Paid: Monthly Quarterly Yearly

Private Health Insurance Yes No

Company:

Premium: \$ Paid: Monthly Quarterly Yearly

Long Term Care Insurance Yes No

Company:

Daily Benefit Amount:

Length of Coverage:

Premium: \$ Paid: Monthly Quarterly Yearly

Long Term Care Insurance Yes No

Company:

Daily Benefit Amount:

Length of Coverage:

Premium: \$ Paid: Monthly Quarterly Yearly

WIFE:

MEDICARE

Traditional Medicare Fee-For-Service Yes No

Or

Medicare HMO, PSO, PPO, or Private Pay Plan Yes No

Company:

Premium: \$ PAID: Monthly Quarterly Yearly

Medicare Supplement (“Medigap”) Yes No

Company:

Type (Plan A through J):

Premium: \$ PAID: Monthly Quarterly Yearly

Medicare Prescription Drug Plan Yes No

Company:

Premium: \$ Paid: Monthly Quarterly Yearly

Employer Retiree Health Plan Yes No

Company:

Premium: \$ Paid: Monthly Quarterly Yearly

Private Health Insurance Yes No

Company:

Premium: \$ Paid: Monthly Quarterly Yearly

Long Term Care Insurance Yes No

Company:

Daily Benefit Amount:

Length of Coverage:

Premium: \$ Paid: Monthly Quarterly Yearly

Long Term Care Insurance Yes No

Company:

Daily Benefit Amount:

Length of Coverage:

Premium: \$ Paid: Monthly Quarterly Yearly

Personal Property

List large items of personal property you own (boats, RVs, farm equipment, etc.) or any valuable collections (antiques, coins, stamps, guns, etc.):

Personal Property (item)	Value
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$

Funeral/Burial

Do either or both of you have prepaid funeral or burial? Yes No

If yes, describe arrangements:

Husband:	
Wife:	

5. ANTICIPATED EXPENSES:

Anticipated maintenance needs to homestead (example: roof, windows, painting, foundation repair, driveway, etc.)

ITEM	COST
	\$
	\$
	\$
	\$
	\$
	\$
	\$

6. MONEY YOU OWE:

CREDITOR'S NAME	AMOUNT OWED
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
TOTAL:	\$

7. 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, 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

8. GIFTS and TRANSFERS:

Have you made any gifts or transfers, greater than \$500.00 to any individuals or to a trust within the last 60 months (5 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: \$

9. ESTATE PLANNING:

Please check the box that applies. Please bring existing documents with you to our meeting.

Do you have any of the following documents?	Husband	Wife
Durable Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No