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LONG TERM CARE – INDIVIDUAL

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 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 if you have any questions or concerns about completing this form.

Date: **Referred by:**

1. PERSONAL INFORMATION

Name (First, Middle, Last):

Name(s) you are also known as:

Date of Birth:

SSN: **Medicare Number:**

Marital Status: ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Are You a Veteran?
☐ **Yes** ☐ **No**
IF YES, BRANCH OF SERVICE: ☐ **AIR FORCE** ☐ **ARMY** ☐ **COAST GUARD** ☐ **MARINES** ☐ **NAVY**
SERVED DURING TIME OF WAR? ☐ **Yes** ☐ **No**
SERVICE DATES:

Is Former Spouse a Veteran?
☐ **Yes** ☐ **No** ☐ **Not Applicable, if never married**
IF YES, BRANCH OF SERVICE: ☐ **AIR FORCE** ☐ **ARMY** ☐ **COAST GUARD** ☐ **MARINES** ☐ **NAVY**
SERVED DURING TIME OF WAR? ☐ **Yes** ☐ **No**
SERVICE DATES:
NAME:
DATE OF BIRTH: DATE OF DEATH:
CITY/STATE OF MARRIAGE:
DATE OF MARRIAGE:
MARRIAGE ENDED WITH DEATH OF SPOUSE: ☐ **Yes** ☐ **No**

Home Address, City, State, Zip:

County of Residence: **US Citizen?** ☐ **Yes** ☐ **No**

Home Phone/Landline: **Cell Phone:**

Home Email:

Contact Information **(if not you, who should we contact for appointments, information, etc.?):**	**Name/Relationship:** **Phone:** **Address/City/ ST/Zip:** **Email:**

2. CHILDREN:

1) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female
Child's Phone:	**# Of Children**

2) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female
Child's Phone:	**# Of Children**

3) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female
Child's Phone:	**# Of Children**

(Continue to next page for more children)

4) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female
Child's Phone:	**# Of Children**

5) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female
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:

	Place Where You Live	Since When?
☐	**Single-family home**	
☐	**Same, but someone assists you there with above activities**	
☐	**Apartment or retirement living community**	
☐	**Assisted-living facility**	
☐	**Nursing home FACILITY:**	DATE OF ADMISSION:
☐	**Other:**	

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

4. RESOURCES:

Monthly Income – GROSS (before taxes & deductions)
(Do not list interest or dividend income)

SOURCE	
Social Security:	$
Pension:	$
Other:	$ $ $
TOTAL:	$

Personal Residence

Address of Property:			
Name(s) as on deed:			
Date Acquired:		**Purchase Price:**	$
Mortgage Company:			
Mortgage Balance:	$	**Tax-Appraised Value:**	$
Current Value:	$		

Other Real Estate

Address of Property:			
Name(s) as on deed:			
Date Acquired:		**Purchase Price:**	$
Mortgage Company:			
Mortgage Balance:	$	**Tax-Appraised Value:**	$
Current Value:	$		

Address of Property:			
Name(s) as 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, 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:	

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):	$

Other Insurance:

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

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 you have prepaid funeral or burial? ☐ Yes ☐ No

If yes, describe arrangements:

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, 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?	
Durable Power of Attorney	☐ **Yes** ☐ **No**
Health Care Power of Attorney	☐ **Yes** ☐ **No**
Directive to Physicians / Living Will	☐ **Yes** ☐ **No**
Last Will and Testament	☐ **Yes** ☐ **No**
Revocable Living Trust	☐ **Yes** ☐ **No**