Early LAW FIRM
Steven A. Early, J.D., CFP®
Attorney At Law

26 Main St.
Colleyville, TX 76034
(817) 605-8880 ● Fax (817) 605-8882
steve@lawyerearly.com / legal@lawyerearly.com

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

Date: **Referred by:**

1. PERSONAL INFORMATION	**HUSBAND:**	**WIFE:**
Name (First, Middle, Last):		
Name(s) you are also known as:		
Date of Birth:		
SSN:		
Medicare Number:		
US Citizen?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Veteran?	☐ **Yes** ☐ **No** IF YES, BRANCH OF SERVICE: ☐ **AIR FORCE** ☐ **ARMY** ☐ **COAST GUARD** ☐ **MARINES** ☐ **NAVY** SERVED DURING TIME OF WAR? ☐ **Yes** ☐ **No** SERVICE DATES:	☐ **Yes** ☐ **No** IF YES, BRANCH OF SERVICE: ☐ **AIR FORCE** ☐ **ARMY** ☐ **COAST GUARD** ☐ **MARINES** ☐ **NAVY** SERVED DURING TIME OF WAR? ☐ **Yes** ☐ **No** SERVICE DATES:
Husband Home Address, City, State, Zip:		
Wife Home Address, City, State, Zip:	☐ **Same as Husband** ☐ **Different**	
County of Residence:		
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 of a previous marriage: ☐ (H) ☐ (W)
Child's Phone:	**# Of Children**

2) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female ---------- ☐ Child of a previous marriage: ☐ (H) ☐ (W)
Child's Phone:	**# Of Children**

3) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female ---------- ☐ Child of a previous marriage: ☐ (H) ☐ (W)
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 of a previous marriage: ☐ (H) ☐ (W)
Child's Phone:	**# Of Children**

5) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female --- ☐ Child of a previous marriage: ☐ (H) ☐ (W)
Child's Phone:	**# Of Children**

6) Child's Full Legal Name:	**Birthdate:**
Child's Address, City, State, Zip: ☐ Deceased	☐ Male / ☐ Female --- ☐ Child of a previous marriage: ☐ (H) ☐ (W)
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?
☐	**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:

WIFE:

	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 GROSS Income (before taxes or deductions)
(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, 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	☐ Yes ☐ No	☐ Yes ☐ No
Health Care Power of Attorney	☐ Yes ☐ No	☐ Yes ☐ No
Directive to Physicians / Living Will	☐ Yes ☐ No	☐ Yes ☐ No
Last Will and Testament	☐ Yes ☐ No	☐ Yes ☐ No
Revocable Living Trust	☐ Yes ☐ No	☐ Yes ☐ No