

DATE: _____

FILE NO.: _____

CLIENT INFORMATION

NAME: _____ SPOUSE'S NAME: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ FAX: _____

CELL PHONE: _____ SPOUSE CELL: _____ EMAIL: _____

SOCIAL SECURITY NO.: _____ DOB: _____ MARITAL STATUS: _____

SPOUSE SOC SEC NO.: _____ SPOUSE DOB: _____

IS SPOUSE DECEASED: ____ YES or ____ NO DOD: _____

ARE YOU A: NEW CLIENT: ____ OR PRESENT/RETURNING CLIENT: ____

ARE YOU A VETERAN or SPOUSE OF A VETERAN? Yes ____ or No ____

REFERRAL SOURCE: _____

OTHER PARTIES:

NAME: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

CITY/STATE: _____ CITY/STATE: _____

PHONE: _____ PHONE: _____

SOC SEC #: _____ SOC SEC #: _____

DATE OF BIRTH: _____ DATE OF BIRTH: _____

EMAIL: _____ EMAIL: _____

TYPE OF CASE - PLEASE CIRCLE BELOW:

ESTATE/PROBATE - WILLS/ESTATE PLANNING - TRUST - REAL ESTATE

ELDER LAW - CONSERVATORSHIP - MISCELLANEOUS:

PURPOSE OF VISIT: _____

I agree to pay all fees and expenses for services rendered, including but not limited to the initial consultation fee of \$300 and all services thereafter which shall be billed at the rate of \$300/hour. I understand that payment is due at the time services are rendered.

CLIENT

CLIENT

NEXT APPOINTMENT: _____

PLEASE ADD MY NAME TO YOUR MONTHLY EMAIL NEWSLETTER LIST: YES ____ NO ____

Asset Accumulation Worksheet

The following worksheet may be helpful in determining the value of your net estate for estate tax purposes. In addition, when designing you plan, it is important to designate how each asset or account is titled (e.g. Joint Tenants with Rights of Survivorship, etc.)

Financial Information

Assets	Value	Titled
		(Self/Spouse/Joint)
Home	\$ _____	_____
Other Real Estate	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Business Interests	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Checking Accounts	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Savings Accounts	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Certificates of Deposit (CDs)	\$ _____	_____
	\$ _____	_____
	\$ _____	_____

(continued...)

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Stocks, Bonds, Mutual Funds	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
IRAs and Retirement Plans	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Annuities	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Life Insurance (Face Value)	\$ _____	_____
	\$ _____	_____
Collectibles (heirlooms, etc.)	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
Personal Property	\$ _____	_____
(estimate replacement value of furnishings, car, clothes)		
Total Asset Value	\$ _____	
DEBTS		
Mortgage	\$ _____	_____
Personal Loans	\$ _____	_____
Other Debts	\$ _____	_____
Total Debt Owed	\$ _____	
Total Asset Value - Total Debt = _____ Net Estate Value		

Income

\$ _____

\$ _____

\$ _____

MEDICAID CHECKLIST

- _____ Asset Accumulation Worksheet
- _____ Date admitted to Nursing Home.
- _____ Copy of Social Security Card.
- _____ SSA Verification Consent Form (Social Security award letter)
- _____ Copy of Medicare Card.
- _____ Copy of Tennessee Driver's License or Voter Registration Card.
- _____ Copy of Birth Certificate.
- _____ Copy of Health Insurance Cards (BCBS, Cigna, TennCare, etc.).
- _____ Deed / Legal papers to any property or other assets sold, mortgaged, or transferred in the past sixty (60) months.
- _____ Property Tax receipts / Deed to house.
- _____ Life Insurance Policy and cash value.
- _____ Health Insurance premium for proof of cost.
- _____ Funeral / Burial Insurance Policy and cash value.
- _____ Proof of ownership of cemetery lot.
- _____ The last 3 bank statements on all accounts, even if closed, with copies of all cancelled checks and all receipts for expenses over \$500.
- _____ Veteran's ID / claim number (must apply if eligible).
- _____ Title to all cars, regardless of condition (proof of sale if sold within the last 3 months).
- _____ Marriage License.
- _____ Divorce Decree, if applicable.
- _____ Power of Attorney
- _____ Copy of spouse death certificate or other proof of death.
- _____ Proof of all gifts made over \$500 in the last sixty (60) months.
- _____ Qualified Income Trust (Include deposit slip for QIT account).
- _____ Proof of Income - all sources (Social Security, Pension, Interest, VA Compensation, etc.)
- _____ Copy of latest tax return and all 1099s.
- _____ PAE letter from TennCare
- _____ Other: _____

If spouse is living in the community:

- _____ Copy of Social Security Card.
- _____ Copy of Medicare Card.
- _____ Proof of Income.
- _____ Copy of latest tax return and all 1099s.
- _____ Utility and telephone bills.
- _____ Proof of rent of house / property taxes.
- _____ Homeowners Insurance.

You MUST pay the resident's liability each month while MEDICAID is pending. The resident's liability is determined by taking the resident's total income and subtracting \$50.00 for personal expenses and any supplemental health insurance policies. The Department of Human Services will approve and send us a final determination of the resident's liability.

Law Office of Nancy L. Choate

CONFIDENTIAL
LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

DATE: _____

SECTION 1. NAME AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

Relationship to Client: _____

Client's Full Name: _____
(first) (middle) (last)

Spouse's Full Name: _____
(first) (middle) (last)

Home Address: _____

Client

Spouse

Telephone Numbers: _____
(home) (home)

_____ (cell) (cell)

Date of Birth: _____

Former/Maiden Names: _____

US Citizen?: [] Yes [] No [] Yes [] No

Social Security Number: _____

Military Service: _____

Date of Death: _____

SECTION 2. MARITAL INFORMATION

A. Date of Marriage: _____

B. Place of Marriage: _____
(city) (state or province) (country)

C. Client's Former Spouses:

1. _____
(name of former spouse) (date of marriage) (place of marriage)

(year terminated) Death Divorce
(how terminated)
 Yes No
(still living?) (if still living, describe relationship)

2. _____
(name of former spouse) (date of marriage) (place of marriage)

(year terminated) Death Divorce
(how terminated)
 Yes No
(still living?) (if still living, describe relationship)

3. _____
(name of former spouse) (date of marriage) (place of marriage)

(year terminated) Death Divorce
(how terminated)
 Yes No
(still living?) (if still living, describe relationship)

D. Spouse's Former Spouses:

1. _____
(name of former spouse) (date of marriage) (place of marriage)

(year terminated) Death Divorce
(how terminated)
 Yes No
(still living?) (if still living, describe relationship)

2. _____
(name of former spouse) (date of marriage) (place of marriage)

(year terminated) Death Divorce
(how terminated)
 Yes No
(still living?) (if still living, describe relationship)

3. _____
(name of former spouse) (date of marriage) (place of marriage)

(year terminated) Death Divorce
(how terminated)
 Yes No
(still living?) (if still living, describe relationship)

SECTION 3. CHILDREN

List all children. Copy and attach additional pages, if needed.

Total number of children: _____

1. _____
(name of child) (date of birth) (social security number)

Parent: Client Spouse Both

(current address) (phone number)

Adopted _____
(date of adoption) (court granting adoption)

Deceased _____ Yes No
(date of death) (child has surviving children?)

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

(Use additional pages, if needed)

2. _____
(name of child) (date of birth) (social security number)

Parent: Client Spouse Both

(current address) (phone number)

Adopted _____
(date of adoption) (court granting adoption)

Deceased _____ Yes No
(date of death) (child has surviving children?)

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

(Use additional pages, if needed)

3. _____
(name of child) (date of birth) (social security number)

Parent: Client Spouse Both

(current address) (phone number)

Adopted _____
(date of adoption) (court granting adoption)

Deceased _____ Yes No
(date of death) (child has surviving children?)

(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

(Use additional pages, if needed)

4. _____ (name of child) _____ (date of birth) _____ (social security number)

Parent: Client Spouse Both

_____ (current address) _____ (phone number)

Adopted _____ (date of adoption) _____ (court granting adoption)

Deceased _____ (date of death) Yes No (child has surviving children?)

 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

 (Use additional pages, if needed)

5. _____ (name of child) _____ (date of birth) _____ (social security number)

Parent: Client Spouse Both

_____ (current address) _____ (phone number)

Adopted _____ (date of adoption) _____ (court granting adoption)

Deceased _____ (date of death) Yes No (child has surviving children?)

 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

 (Use additional pages, if needed)

6. _____ (name of child) _____ (date of birth) _____ (social security number)

Parent: Client Spouse Both

_____ (current address) _____ (phone number)

Adopted _____ (date of adoption) _____ (court granting adoption)

Deceased _____ (date of death) Yes No (child has surviving children?)

 (Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

 (Use additional pages, if needed)

SECTION 4. DISPOSITIVE PLANNING

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 of child, etc.).

A. First-choice beneficiaries: Spouse Children Spouse and Children Other

B. Second-choice beneficiaries: Spouse Children Spouse and Children Other

C. Third-choice beneficiaries: Spouse Children Spouse and Children Other

D. Any specific disposition of your residence?

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

F. Any specific disposition of household and personal effects?

G. Other information you think is important to your estate planning:

SECTION 5. FIDUCIARIES

Please consider the who you want to handle your affairs when you cannot. *We will discuss this section at our conference and will assist you with the completion.*

A. EXECUTORS (Co-Executors Act: Separately or Jointly)

1. _____ (name) _____ (relationship)

_____ (current address) _____ (phone number)

2. _____ (name) _____ (relationship)

Co-Executor with Previous Name (May surviving Co-Executor act alone? Yes No)
or Successor Executor

_____ (current address) _____ (phone number)

3. _____ (name) _____ (relationship)

Co-Executor with Previous Name (May surviving Co-Executor act alone? Yes No)
or Successor Executor

_____ (current address) _____ (phone number)

4. _____ (name) _____ (relationship)

Co-Executor with Previous Name (May surviving Co-Executor act alone? Yes No)
or Successor Executor

_____ (current address) _____ (phone number)

B. TRUSTEES (Co-Trustees Act: Separately or Jointly)

1. _____ (name) _____ (relationship)

_____ (current address) _____ (phone number)

2. _____ (name) _____ (relationship)

Co-Trustee with Previous Name (May surviving Co-Trustee act alone? Yes No)
or Successor Trustee

_____ (current address) _____ (phone number)

3. _____ (name) _____ (relationship)
[] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [] Yes [] No)
or [] Successor Trustee

(current address)

(phone number)

4. _____ (name) _____ (relationship)
[] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [] Yes [] No)
or [] Successor Trustee

(current address)

(phone number)

C. GUARDIANS OF MINOR CHILDREN (Co-Guardians Act: [] Separately or [] Jointly)

1. _____ (name) _____ (relationship)

(current address)

(phone number)

2. _____ (name) _____ (relationship)
[] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [] Yes [] No)
or [] Successor Guardian

(current address)

(phone number)

3. _____ (name) _____ (relationship)
[] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [] Yes [] No)
or [] Successor Guardian

(current address)

(phone number)

4. _____ (name) _____ (relationship)
[] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [] Yes [] No)
or [] Successor Guardian

(current address)

(phone number)

D. AGENTS UNDER POWER OF ATTORNEY (Co-Agents Act: Separately or Jointly)

1. _____
(name) (relationship)

(current address) (phone number)

2. _____
(name) (relationship)

Co-Agent with Previous Name (May surviving Co-Agent act alone? Yes No)
or Successor Agent

(current address) (phone number)

3. _____
(name) (relationship)

Co-Agent with Previous Name (May surviving Co-Agent act alone? Yes No)
or Successor Agent

(current address) (phone number)

4. _____
(name) (relationship)

Co-Agent with Previous Name (May surviving Co-Agent act alone? Yes No)
or Successor Agent

(current address) (phone number)

E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY

1. _____
(name) (relationship)

(current address) (phone number)

2. _____
(name) (relationship)

(current address) (phone number)

3. _____
(name) (relationship)

(current address) (phone number)

4. _____
(name) (relationship)

(current address) (phone number)

SECTION 6. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

B. Spouse

SECTION 7. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: Yes No

Spouse: Yes No

If yes, please explain:

B. OTHER ISSUES

	<u>Client</u>	<u>Spouse</u>
Able to sign name?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to speak?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to recognize friends and family?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cognizant of property and possessions?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Able to leave current residence?:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 8. PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of your primary physician.

	<u>Client</u>	<u>Spouse</u>
Physician's Name:	_____	_____
Specialty:	_____	_____
Address:	_____	_____
	_____	_____
Business Phone:	_____	_____

SECTION 9. RESIDENCE -- OWNED

- A. Owners: _____
- B. How is title held? _____

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

- C. Fair Market Value: \$ _____
- D. Mortgage Balance: \$ _____
- Is it a Reverse Annuity Mortgage (RAM)? Yes No
- Basic Mortgage Terms: _____

- E. Single Family Residence? Yes No

F. If the property is rental property, 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 Inherited: _____
2. Value when Inherited: \$ _____

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

J. Have the owners used the capital gains tax exclusion? Yes No

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

1. If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? Yes No

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

L. Does the person needing care have any living children who are disabled? Yes No

If yes, please describe the nature of the disability:

M. Does the owner have a sibling who has lived in the house for at least 1 year? Yes No

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

SECTION 10. RESIDENCE -- RENTED

A. Monthly Rent: \$ _____

B. Type of Rental: Single Family Apartment Residential Care
 Life Care Senior Housing

C. Rental/Lease Agreement? Yes No

D. Is Rent Subsidized? Yes No

If so, by whom and amount? _____

SECTION 11. LONG-TERM CARE (LTC)

A. Client

Currently Receiving LTC? Yes No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

Business Phone: _____

Administrator or Contact: _____

B. Spouse

Currently Receiving LTC? Yes No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

Business Phone: _____

Administrator or Contact: _____

SECTION 12. HOSPITAL

A. Client

Currently in Hospital? Yes No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

Is LTC placement expected? Yes No

If so, likely to return home? Yes No

B. Spouse

Currently in Hospital? [] Yes [] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

Is LTC placement expected? [] Yes [] No

If so, likely to return home? [] Yes [] No

SECTION 13. INCOME

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.

A. FIXED MONTHLY INCOME

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Social Security:	\$ _____	\$ _____	\$ _____
2. R.R. Retirement:	\$ _____	\$ _____	\$ _____
3. Pension:	\$ _____	\$ _____	\$ _____
4. _____:	\$ _____	\$ _____	\$ _____
5. _____:	\$ _____	\$ _____	\$ _____
6. _____:	\$ _____	\$ _____	\$ _____

B. NON-FIXED MONTHLY INCOME

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Interest:	\$ _____	\$ _____	\$ _____
2. Dividends:	\$ _____	\$ _____	\$ _____
3. _____:	\$ _____	\$ _____	\$ _____
4. _____:	\$ _____	\$ _____	\$ _____
5. _____:	\$ _____	\$ _____	\$ _____

C. TOTALS (A thru B): \$ _____ \$ _____ \$ _____

_____ \$
 _____ \$

D. REAL ESTATE
 (Please provide copies of deeds and most recent tax bills)

<u>Description (Location)</u>	<u>Cost (Basis)</u>	<u>Market Value</u>	<u>Mortgage Bal.</u>	<u>How Title Held</u>
123 Know Way (sample)	\$ 120,000	\$ 180,000	\$ 85,321.87	Joint tenant
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	

E. PERSONAL PROPERTY

	<u>Market Value</u>	<u>How Title Held</u>
Home Furnishings:	\$	
Cars, RVs, Boats, etc.:	\$	
Jewels, Furs, etc.:	\$	
: (other: collectibles, etc.)	\$	
:	\$	
:	\$	

F. BUSINESS INTERESTS

If the person needing long-term care has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which the person needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

H. MISCELLANEOUS

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each.

SECTION 15. 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.

	<u>Client</u>	<u>Spouse</u>
Burial plot:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irrevocable burial fund contract:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 16. PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

A. Responsible for Client:

1. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
2. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
3. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)

B. Responsible for Spouse:

1. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
2. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)
3. _____ (name of responsible person) _____ (phone number) _____ (relationship to person needing care)

SECTION 17. UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

SECTION 18. MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*: \$	_____	_____	_____
2. If home is rented, total rent, including maint. fees, if any: \$	_____	_____	_____

* Is the senior citizen real property tax exemption being used? [] Yes [] No
 Is the veterans real property tax exemption being used? [] Yes [] No

B. INSURANCE PREMIUMS (PER MONTH)

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Health insurance:	\$ _____	\$ _____	\$ _____
2. Long-term care insurance:	\$ _____	\$ _____	\$ _____
3. _____ : (specify)	\$ _____	\$ _____	\$ _____
4. _____ : (specify)	\$ _____	\$ _____	\$ _____

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Non-covered medications:	\$ _____	\$ _____	\$ _____
2. _____ : (specify)	\$ _____	\$ _____	\$ _____
3. _____ : (specify)	\$ _____	\$ _____	\$ _____

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

	<u>Client</u>	<u>Spouse</u>	<u>Joint</u>
1. Food:	\$ _____	\$ _____	\$ _____
2. Entertainment and travel:	\$ _____	\$ _____	\$ _____
3. Support for children:	\$ _____	\$ _____	\$ _____
4. _____ : (specify)	\$ _____	\$ _____	\$ _____
5. _____ : (specify)	\$ _____	\$ _____	\$ _____
E. TOTALS (A thru D):	\$ _____	\$ _____	\$ _____

SECTION 19. HEALTH AND LTC INSURANCE

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

<u>Name of Insurer</u>	<u>Policy No.</u>	<u>Type of Policy</u>	<u>Monthly Prem.</u>	<u>If LTC, Daily Benefit</u>
<u>Acme Insurance</u> (sample)	<u>123-45-6789</u>	<u>Long-term care</u>	<u>\$ 3,000</u>	<u>\$ 300.00 per day</u>
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

_____ \$ _____ \$
 _____ \$ _____ \$

SECTION 20. PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	<u>Client</u>	<u>Spouse</u>
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 (or Proxy):	[] Yes [] No	[] Yes [] No
Living Will:	[] Yes [] No	[] Yes [] No
_____:	[] Yes [] No	[] Yes [] No
(specify)		
_____:	[] Yes [] No	[] Yes [] No
(specify)		
_____:	[] Yes [] No	[] Yes [] No
(specify)		

SECTION 21. TRANSFERS WITHIN 60 MONTHS

Has the person needing care transferred property to someone other than his or her spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**:

A. Client

	<u>Recipient</u>	<u>Amount/Value of Gift</u>	<u>Date of Gift</u>
1.	_____	\$ _____	_____
2.	_____	\$ _____	_____
3.	_____	\$ _____	_____
4.	_____	\$ _____	_____

B. Spouse

	<u>Recipient</u>	<u>Amount/Value of Gift</u>	<u>Date of Gift</u>
1.	_____	\$ _____	_____
2.	_____	\$ _____	_____

