ELDER LAW PLANNING QUESTIONNAIRE

Name of Client	

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. If there is not enough space on the form for your answer to any question, attach an additional page to the form with a reference to the question you are answering.

Please bring the completed form with you to your appointment.

SECTION 1. CONTACT PERSON 3

SECTION 2. CLIENT DETAILS 4

2.1. CLIENT NAME, ADDRESS AND DOMICILE 4
2.2. CLIENT DATA 4

SECTION 3. MEDICAL DATA. 5

SECTION 4. INCOME & EXPENSES 6

4.1. MONTHLY INCOME FOR CLIENT 6
4.2. MONTHLY SHELTER EXPENSES FOR CLIENT 6
4.3. MONTHLY NON-SHELTER EXPENSES FOR CLIENT 7
4.4. NURSING HOME COST FOR CLIENT 7

SECTION 5. ASSET INVENTORY AND DETAILS 8

5.1. NON-COUNTABLE ASSETS 8
5.2. COUNTABLE ASSETS 8
5.2.1. CHECKING 8
5.2.2. SAVINGS 8
5.2.3. MONEY MARKET 8
5.2.4. SAVINGS CERTIFICATES 8
5.2.5. AUTOMOBILE 8
5.2.6. OTHER REAL ESTATE 8
5.2.7. BROKERAGE/CAP ACCTS 8
5.2.8. MUTUAL FUNDS 9
5.2.9. STOCKS 9
5.2.10. BONDS 9
5.2.11. ANNUITIES 9
5.2.12. CASH VALUE LIFE INSURANCE 9
5.2.13. TRADITIONAL IRA 9
5.2.14. ROTH IRA 9
5.2.15. RETIREMENT ACCOUNTS 9

5.2.16. Other Assets ... 9
5.2.17. Total Countable Assets ... 10
5.3. Residence Information ... 10
5.4. Life Insurance ... 10

SECTION 6. PRIOR TRANSACTIONS ... 12

6.1. Gifts to an Individual or to a Trust ... 12
6.2. Federal Gift Tax Returns ... 12
6.3. Real Estate Transfers ... 12

SECTION 7. INTERESTED PARTIES ... 14

7.1. Children ... 14
7.2. Other Interested Parties ... 16

SECTION 8. OTHER ISSUES ... 16

SECTION 9. REFERRAL ... 17

SECTION 10. CERTIFICATION ... 17

SECTION 1. CONTACT PERSON

Client Communications	
All communications re: Elder Law Planning matter should be addressed to	☐ Client ☐ Include a Child/Relative/Other
If child or other, Name of Contact	
Gender of this other party	☐ Male ☐ Female
Street Address	
Apt/Suite/Floor	
City, State, Zip	
Telephone Numbers	Home
	Cell
	Work

SECTION 2. CLIENT DETAILS

2.1. CLIENT NAME, ADDRESS and DOMICILE

Name of Client	
Gender of Client	☐ Male ☐ Female
Name prefix	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Ms. ☐ Dr. ☐ Pastor ☐ Prof. ☐ Rev. ☐ __________
Suffix	☐ Jr. ☐ II ☐ III ☐ IV ☐ ___________
Does the client have a nickname?	☐ Yes ☐ No
If yes, what is the nickname?	
Does the client use an alias name?	☐ Yes ☐ No
If yes, what is that alias?	
DOB	
Social Security Number	
Client is U.S. citizen	☐ Yes ☐ No
If not a U.S. citizen, client is citizen of	
Contact Info and Address(es)	
Street Address 1	
Street Address 2	
City, State, Zip	
Telephone Numbers	Home
	Cell
	Work
Domicile Details	
State of legal domicile is different from client's "address" state, above?	☐ Yes ☐ No
If yes, state of Legal Residence	

2.2. Client Data

Client Data	
Has Client has been diagnosed with an illness?	☐ Yes ☐ No
Is Client a veteran?	☐ Yes ☐ No
If yes, is Client receiving Tricare?	☐ Yes ☐ No

SECTION 3. <u>MEDICAL DATA.</u>

HEALTH INFORMATION		
Health of Client		☐ is in reasonably good health ☐ suffers from (specify diagnosis)
Specify Diagnosis		(check all that apply)
	☐ Alzheimer's Disease ☐ Aneurysm ☐ Arterial Fibrillation ☐ Arthritis ☐ Back Pain ☐ Bedsores ☐ Cancer ☐ Carotid Arteries ☐ Cellulitis ☐ Cholesterol (high) ☐ Colon Cancer ☐ Congestive Heart Failure ☐ COPD ☐ Coronary Artery Disease ☐ Delirium ☐ Dementia ☐ Depression ☐ Diabetes ☐ Emphysema ☐ Encephalitis ☐ Epilepsy ☐ Frailty resulting from age ☐ Glaucoma	☐ Hearing Loss ☐ Heart Attack (effects of previous) ☐ Heart Disease ☐ Hip Fracture (effects of) ☐ Hypertension ☐ Knee Surgery (effects of) ☐ Krohn's Disease ☐ Lung Cancer ☐ Macular Degeneration ☐ Multiple Sclerosis ☐ Neuropathy ☐ Osteoarthritis ☐ Osteoporosis ☐ Parkinson's Disease ☐ Prostate Problems ☐ Quadruple Bypass ☐ Rheumatoid Arthritis ☐ Spinal Stenosis ☐ Stroke (effects of prior) ☐ Thyroid Condition ☐ Other ________________________ ☐ ______________________________ ☐
Client's Physician		
Do you know the name of Client's Physician?		☐ Yes ☐ No
If yes, Name of Client's Physician		
Street Address		
Suite / Office # / Address 2		
City, State, Zip		
Telephone Numbers		Home
		Cell
		Work

SECTION 4. INCOME & EXPENSES

4.1. Monthly Income For Client

Monthly Income for Client	Amount		
Net Social Security			
Medicare Part B Deduction (Select or enter a number)	☐ $94.60	☐ $134.90	☐ $192.70
	☐ $250.50	☐ $308.30	☐ $_______
Medicare Part D			
Pension/Retirement Benefits (Gross)			
Employment			
Disability			
Annuity			
Rental			
Other Income			

	Item	Amount
1		
2		
3		
4		
Total Income		

4.2. Monthly Shelter Expenses For Client

Monthly Shelter Expenses for Client	Amount
Rent Payments (monthly)	
Mortgage Payments (monthly)	
Real Estate Taxes (monthly)	
Water	
Sewer	
Trash disposal fees	
Average Monthly Utilities Bill (Heat, Electric & Telephone) (1/12 of expenses for last 12 months)	
Homeowner's Insurance Premium	
Condominium fees	
Other Shelter Expenses	

	Item	Amount
1		
2		
3		
4		
Total Shelter Expenses		

4.3. Monthly Non-Shelter Expenses For Client

Monthly Non-Shelter Expenses for Client		
Food		
Medical		
Clothing		
Transportation		
Home Maintenance		
Life Insurance Premium		
Health Insurance Premium		
Cable TV		
Federal and State Income Taxes		
Other Non-Shelter Expenses		
	Item	**Amount**
1		
2		
3		
4		
Total Nonshelter Expenses		

4.4 Nursing Home Cost For Client

Estimated/Actual Cost of Nursing Home Care for Client		**Amount**
Facility Cost		
Prescription Cost		
Incontinent Cost		
Medical Insurance Cost		
Are there any other Costs?		☐ Yes ☐ No
Other Nursing Home Costs		
	Item	**Amount**
1		
2		
3		
4		
5		
6		

Total Nursing Home Costs	

SECTION 5. ASSET INVENTORY AND DETAILS

5.1. Non-Countable Assets

Item	Client	Joint w/ Another	Liability
Home			
Automobile			
Personal Effects			
Pre-paid Funeral (in irrevocable Trust)			

5.2. Countable Assets

5.2.1. Checking

Item	Client	Joint w/ Another	Liability

5.2.2. Savings

Item	Client	Joint w/ Another	Liability

5.2.3. Money Market

Item	Client	Joint w/ Another	Liability

5.2.4. Savings Certificates

Item	Client	Joint w/ Another	Liability

5.2.5. Automobile

Item	Client	Joint w/ Another	Liability

5.2.6. Other Real Estate

Item	Client	Joint w/ Another	Liability

5.2.7. Brokerage/Cap Accts

Item	Client	Joint w/ Another	Liability

5.2.8. **Mutual Funds**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.9. **Stocks**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.10. **Bonds**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.11. **Annuities**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.12. **Cash Value Life Insurance**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.13. **Traditional Ira**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.14. **Roth Ira**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.15. **Retirement Accounts**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.16. **Other Assets**

Item	**Client**	**Joint w/ Another**	**Liability**

5.2.17. Total Countable Assets

	Client	Joint w/ Another	Liability

5.3. Residence Information

Residence	
Purchase Price	
Purchase Costs (title & escrow fees, real estate agent commissions, etc.)"	
Improvements	
Selling Costs (title & escrow fees, real estate agent commissions, etc.)"	
Accumulated Depreciation	
Cost Basis	
Amount of Unified Credit Available	
Ownership History	
Has client owned the property for 2 of the last 5 years?	☐ Yes ☐ No
Has client occupied the property for 2 of the last 5 years?	☐ Yes ☐ No

5.4. Life Insurance

Life Insurance Policies	

First Policy	
Name of Company	
Policy Number	
Address of Company	
Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit ($)	
Face Value ($)	
Cash Value ($)	

Second Policy	
Name of Company	
Policy Number	
Address of Company	

Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit ($)	
Face Value ($)	
Cash Value ($)	

Third Policy	
Name of Company	
Policy Number	
Address of Company	
Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit ($)	
Face Value ($)	
Cash Value ($)	

Fourth Policy	
Name of Company	
Policy Number	
Address of Company	
Phone	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit ($)	
Face Value ($)	
Cash Value ($)	

SECTION 6. PRIOR TRANSACTIONS

6.1. Gifts to an Individual or to a Trust

Gifts to an Individual or to a Trust	
Has Client made any gifts within last five years to an individual or to a trust?	☐ Yes ☐ No
If "Yes", describe the gift(s) in the spaces provided	

First Gift	
Name of Recipient	
Date of Gift	
Amount	

Second Gift	
Name of Recipient	
Date of Gift	
Amount	

Third Gift	
Name of Recipient	
Date of Gift	
Amount	

Fourth Gift	
Name of Recipient	
Date of Gift	
Amount	

Fifth Gift	
Name of Recipient	
Date of Gift	
Amount	

6.2. Federal Gift Tax Returns

Federal Gift Tax Returns	
Has Client ever filed a Federal Gift Tax Return?	☐ Yes ☐ No
If yes, provide copies of returns.	

6.3. Real Estate Transfers

Real Estate Transfers	
Has Client sold or otherwise transferred any real property within the last two years?	☐ Yes ☐ No
If yes, how many sales/transfers?	

First Transfer	
Address of Property	
Cost Basis	
Sale Price	
Date of Sale	

Second Transfer	
Address of Property	
Cost Basis	
Sale Price	
Date of Sale	

SECTION 7. INTERESTED PARTIES

7.1. Children

Name of Child #1	
Gender	☐ Male ☐ Female
Date of Birth	
Is Child a minor?	☐ Yes ☐ No
Child's address:	
Telephone	
Child is (check all that apply)	☐ Disabled ☐ Blind
Child's problems (check all that apply)	☐ Poor health ☐ Drug addiction or alcoholism ☐ Spendthrift
Is child is receiving SSI or another form of government entitlement	☐ Yes ☐ No
If yes, entitlement from	
If yes, specify monthly payment	

Name of Child #2	
Gender	☐ Male ☐ Female
Date of Birth	
Is Child a minor?	☐ Yes ☐ No
Child's address:	
Telephone	
Child is (check all that apply)	☐ Disabled ☐ Blind
Child's problems (check all that apply)	☐ Poor health ☐ Drug addiction or alcoholism ☐ Spendthrift
Is child is receiving SSI or another form of government entitlement	☐ Yes ☐ No
If yes, entitlement from	
If yes, specify monthly payment	

Name of Child #3	
Gender	☐ Male ☐ Female
Date of Birth	
Is Child a minor?	☐ Yes ☐ No
Child's address:	
Telephone	
Child is (check all that apply)	☐ Disabled ☐ Blind
Child's problems (check all that apply)	☐ Poor health ☐ Drug addiction or alcoholism ☐ Spendthrift
Is child is receiving SSI or another form of government entitlement	☐ Yes ☐ No
If yes, entitlement from	
If yes, specify monthly payment	

Name of Child #4	
Gender	☐ Male ☐ Female
Date of Birth	
Is Child a minor?	☐ Yes ☐ No
Child's address:	
Telephone	
Child is (check all that apply)	☐ Disabled ☐ Blind
Child's problems (check all that apply)	☐ Poor health ☐ Drug addiction or alcoholism ☐ Spendthrift
Is child is receiving SSI or another form of government entitlement	☐ Yes ☐ No
If yes, entitlement from	
If yes, specify monthly payment	

7.2. Other Interested Parties

First Party	
Name	
Gender	☐ Male ☐ Female ☐ Entity
Relation to Client	
Street Address	
Telephone	

Second Party	
Name	
Gender	☐ Male ☐ Female ☐ Entity
Relation to Client	
Street Address	
Telephone	

Third Party	
Name	
Gender	☐ Male ☐ Female ☐ Entity
Relation to Client	
Street Address	
Telephone	

SECTION 8. OTHER ISSUES

Other Issues		
Are there any other legal issues that I should be aware of?		☐ Yes ☐ No
If yes, list the issues below		
	Issue	**Importance**
1		☐ Major ☐ Moderate ☐ Inquiry
2		☐ Major ☐ Moderate ☐ Inquiry

Other Issues		
Are there any other legal issues that I should be aware of?		☐ Yes ☐ No
If yes, list the issues below		
3		☐ Major ☐ Moderate ☐ Inquiry
4		☐ Major ☐ Moderate ☐ Inquiry
5		☐ Major ☐ Moderate ☐ Inquiry

SECTION 9. REFERRAL

Referral Details	
By whom were you referred to this office	
Name / Firm	
Street Address	
Apt/Suite/Floor	
City, State, Zip	
Telephone	
Referrer is	☐ Attorney ☐ Financial Planner ☐ Previous Client of Law Firm ☐ Doctor ☐ Social Worker ☐ Other ________________

SECTION 10. CERTIFICATION

The undersigned hereby represents to Maureen P. Gluntz, Attorney at Law, that the information contained in this questionnaire is accurate and complete, and that the undersigned understands that the law firm will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

_______________________________________ _______________________________

Name Date