

**ELDER CARE PLANNING QUESTIONNAIRE
(MARRIED)**

Date _____
Home Phone No. _____
E-mail Address _____

File No. _____
Business Phone No. _____
Fax No. _____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to the appointment.

A. PERSONAL DATA

(Husband)

(Wife)

Full Name _____
(Print name as shown on your checks.)

Full Name _____
(Print name as shown on your checks.)

Street Address _____

City _____ State _____ Zip _____

(Husband)

(Wife)

Birth Date _____

Birth Date _____

Social Security No. _____

Social Security No. _____

U.S. Citizen? Yes No

U.S. Citizen? Yes No

Veteran? Yes No

Veteran? Yes No

B. MEDICAL DATA

1. HEALTH

Name of Ill Spouse _____

Diagnosis _____

Prognosis _____ Course of Treatment _____

If Ill Spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis _____

Name of Well Spouse _____

Where Well Spouse Currently Resides _____

Health of Well Spouse _____

2. PHYSICIAN

Full Name of Husband's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

Full Name of Wife's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

3. STATE PHARMACEUTICAL PLAN

Are you currently on PACE (Pharmaceutical Assistance Contract for the Elderly) or any other state pharmaceutical plan? Yes No

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (include \$66.60 Medicare Part B Deduction, if applicable)	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
Veterans Disability Income	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____	\$ _____

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future? Yes No

Do not include interest and dividend income on this form.

D. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost	\$ _____
Monthly Prescription Cost	\$ _____
Monthly Incontinent Cost	\$ _____
Monthly Other Cost	\$ _____
Total Monthly Cost	\$ _____

The nursing home is paid through _____ (month/year).

E. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage	\$ _____
Real Estate Taxes	\$ _____
Water	\$ _____
Sewer	\$ _____
Utilities (Heat, Electric & Telephone) (1/12th of last 12 months)	\$ _____
Homeowner's insurance premium	\$ _____
Condominium fees	\$ _____
Total Monthly Housing Expenses	\$ _____

F. MONTHLY NON-SHELTER LIVING EXPENSES

Food	\$ _____
Medical	\$ _____
Clothing	\$ _____
Transportation (including auto insurance)	\$ _____
Home Maintenance	\$ _____
Life Insurance Premiums	\$ _____
Health Insurance Premiums	\$ _____

Cable TV \$ _____
 Federal and State Income Taxes \$ _____
 Other \$ _____
Total Monthly Non-Shelter Living Expenses \$ _____

G. GIFTS

Have you made gifts in excess of \$5,000 in any one month, to an individual or group of individuals, within the past 36 months, or to a trust within the past 60 months? Yes No

If yes, list below:

Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

If so, please state details _____

H. LIFE INSURANCE/LONG TERM CARE INSURANCE

Name of Insurance Company _____ **Policy #** _____
 Street Address _____
 City _____ State _____ Zip _____
 Type of Policy _____ Owner _____
 Insured _____ Beneficiary _____
 Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy #** _____

Street Address _____

City _____ State _____ Zip _____

Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value \$ _____ Cash Value \$ _____

I. CHILDREN (if applicable)

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Social Security Number _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Social Security Number _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Social Security Number _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Social Security Number _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Date of Birth _____ Social Security Number _____

Does the Husband have any children by a previous marriage? Yes No

Does the Wife have any children by a previous marriage? Yes No

Are all of your children in good health? Yes No

Are any of your children blind? Yes No

Are any of your children disabled? Yes No

Are any of your children receiving SSI or other form of government entitlement? Yes No

Do any of your family members have any problems with:

Aids	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drug Addiction?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Alcoholism?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Spendthrift?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do any of your children live with you in your home? Yes No

If yes, name of child _____

J. MISCELLANEOUS

Do you have any other legal issues which I should be aware of: Yes No

If yes, please explain _____

1. REFERRAL

By whom were you referred to this office?

Name _____

Street Address _____

City _____ State _____ Zip _____

Have you visited our Website? Yes No

Do you have any ideas for improving our Website? If so, please discuss.

2. CERTIFICATION

The undersigned hereby represents to Springer Bush & Perry P.C., and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers 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:

ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space.

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
Personal Effects				
Automobile				
Checking Account				
Savings Account				
Money Market Account				
Certificates of Deposit				
Residence (Assessed Value) Block # _____ Lot # _____ (Obtain from Tax Bill)				
Other Real Estate				
Additional Automobiles				
Mutual Funds				
Stocks				
Bonds				
Annuities				
Cash Value - Life Insurance				
IRA				
Nursing Home Deposit				
Other				
Other				
TOTALS				

What did you pay for your current home including any improvements? \$ _____

Address of any real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____
Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____

(2) Street _____ City _____ State _____ Zip _____
Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____
Name of Homeowner's Insurance Company _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Policy No. _____

Print out this form and complete it. You may fax it to 412-269-9638 or mail it to the address below.

Julian E. Gray, CELA
C/O500 Cherrington Parkway, Suite 420
Coraopolis, Pennsylvania 15108-4749
Tel. 412- 269-4200 Fax 412-269-9638