

**ELDER CARE PLANNING QUESTIONNAIRE
(SINGLE)**

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

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

Street Address _____

City _____ State _____ Zip _____

Birth Date _____ Social Security No. _____

U.S. Citizen? Yes No Veteran? Yes No

If widowed, please list name of spouse and date of death _____

Was your former spouse a Veteran? Yes No

B. MEDICAL DATA

1. HEALTH

Diagnosis _____

Prognosis _____

Course of Treatment _____

If you are already in a nursing home, please indicate the name of the nursing home and the date first entered _____

2. PHYSICIAN

Full Name of 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

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. 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 _____
Recipient _____	Date _____	Amount _____

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

If so, please state details

F. 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 \$ _____

G. 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 _____

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 No

Drug Addiction? Yes No

Alcoholism? Yes No

Spendthrift? Yes No

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

If yes, name of child _____

Does a sibling live in your home with you? Yes No

If yes, name of sibling _____

H. 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.

10. 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.

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