J.L. Williamson Law Group LLC

CONFIDENTIAL LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire will help us gather the information necessary to properly plan to protect your assets or the assets of a family member or friend. Questions that do not apply to you, your family, or your financial situation may be ignored. Please attach additional pages where space is insufficient or to provide other relevant information.

SECTION 1. NAME AND CONTACT INFORMATION

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

Home Address: _____

_____

Relationship to Client: _____

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

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

Home Address: _____

_____

	Client	**Spouse**
Telephone Numbers:	_____ (home)	_____ (home)
	_____ (cell)	_____ (cell)
Date of Birth:	_____	_____
Former/Maiden Names:	_____	_____
US Citizen?:	[ ] Yes [ ] No	[ ] Yes [ ] No

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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)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

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

_____ [ ] Death [ ] Divorce
(year terminated) (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)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

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

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

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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"? 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"? 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?)

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(Describe this child. Does he or she have "special needs"? 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 _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child. Does he or she have "special needs"? 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 _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child. Does he or she have "special needs"? 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 nonprofit organizations, educational, or religious organizations. Consider to whom (charities, other siblings, spouse of child, etc.) your property should go if your first-choice beneficiaries do not survive you, or if those beneficiaries do not survive until complete distribution is made should the property be left in a trust.

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

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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 or other information you think is important to your estate planning?

SECTION 5. FIDUCIARIES

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

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

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)

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[ ] 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)

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

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(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)

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)

E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(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

	Client	Spouse
Able to sign name?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to speak?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to recognize friends and family?:	[ ] Yes [ ] No	[ ] Yes [ ] No

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Cognizant of property and possessions?: [ ] Yes [ ] No [ ] Yes [ ] No

Able to leave current residence?: [ ] Yes [ ] No [ ] Yes [ ] No

SECTION 8. PHYSICIAN INFORMATION

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

	Client	**Spouse**
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: $ _____

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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? _____

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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

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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

		Client	Spouse	Joint
1.	Social Security:	$	$	$
2.	R.R. Retirement:	$	$	$
3.	Pension:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$

B. NON-FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Interest:	$	$	$
2.	Dividends:	$	$	$
3.	_____:	$	$	$
4.	_____:	$	$	$
C.	**TOTALS (A thru B):**	**$**	**$**	**$**

SECTION 14 ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.) (Please provide copies of statements)

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Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
			$	
			$	
			$	
			$	
			$	$

B. SECURITIES (Bonds, Marketable Securities, etc.)
(Please provide copies of statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)
(Please provide copies of statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Estab.	Current Value
					$
					$
					$
					$

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

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
	$	$	$	
	$	$	$	
	$	$	$	

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_____ $_____ $_____ $_____ _____

E. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$_____	_____
Cars, RVs, Boats, etc.:	$_____	_____
Jewels, Furs, 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, relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, 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

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long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

	Client	Spouse
Burial plot:	[ ] Yes [ ] No	[ ] Yes [ ] No
Irrevocable burial fund contract:	[ ] Yes [ ] No	[ ] Yes [ ] 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)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship)

B. Responsible for Spouse:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship)

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)

	Client	Spouse	Joint
1.If home is owned, include total cost of mortgage, taxes, utilities, and phone, etc.:	$ _____	$ _____	$ _____

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2. If home is rented, total rent,
including maintenance 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)

		Client	Spouse	Joint
1.	Health insurance:	$_____	$_____	$_____
2.	Long-term care insurance:	$_____	$_____	$_____
3.	_____:	$_____	$_____	$_____

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Non-covered medications:	$_____	$_____	$_____
2.	_____:	$_____	$_____	$_____
3.	_____:	$_____	$_____	$_____

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Food:	$_____	$_____	$_____
2.	Entertainment and travel:	$_____	$_____	$_____
3.	Support for children:	$_____	$_____	$_____
4.	_____:	$_____	$_____	$_____
5.	_____:	$_____	$_____	$_____
E.	**TOTALS (A thru D):**	**$**_____	**$**_____	**$**_____

SECTION 19. HEALTH AND LONG-TERM CARE 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:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
_____	_____	_____	$_____	$_____

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_____	_____	_____	$ _____	$ _____
_____	_____	_____	$ _____	$ _____

SECTION 20. PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	Client	Spouse
Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Health Care Power of Attorney (or Proxy):	[ ] Yes [ ] No	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No	[ ] Yes [ ] No
_____:	[ ] Yes [ ] No	[ ] Yes [ ] No

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

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

B. Spouse

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

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SECTION 22. TRANSFERS TO OR FROM TRUSTS

Has the person needing care transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

A. Client

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

B. Spouse

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

SECTION 23. CLIENT'S GOALS

What are your estate and long-term care planning goals?

_____

_____

_____

_____

_____

_____

_____

_____

[*The remainder of this page is intentionally left blank. Required signatures are on the following page.*]

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SECTION 24. CERTIFICATION

I, the undersigned, represent to J. L. Williamson Law Group, LLC, and each of its attorneys and paralegals, that the information contained in this Long-Term Care Planning Questionnaire is accurate and complete, and that I understand that the law firm and its individual lawyers will rely on this information. I further understand that if the information contained herein is inaccurate or incomplete, the recommendations made by J. L. Williamson Law Group, LLC, may not be appropriate.

Signature of Client or Client Representative:

_____ _____

Name Date

Signature of Spouse or Spouse Representative:

_____ _____

Name Date

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