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HEALTHCARE COST PLANNING QUESTIONNAIRE

This form is extremely important in determining your individual needs and current situation. Your accuracy and completeness will help me to best represent you. Please take time to complete all applicable sections. We cannot begin our assessment until we have complete and accurate information from you. Please also list names as they would appear on legal documents. You may use the back of each page if you need additional space to provide complete information. Should you need assistance in completing this form, please call and we will be happy to assist you.

Name and current living situation:

Name: _____

Nursing home of ALF information:

Home___ Nursing facility___ALF___

Name of Facility_____

Address_____

Room/Apt.#_____

City_____State___Zip_____

County_____

Telephone_____

Date of Admission_____

Primary Home Information:

Address_____

City_____State___Zip_____

County_____

Telephone_____

E-mail_____

Social Security #_____

Date of Birth_____

U.S. citizen: Yes___No___

Resided in Florida since_____

FAMILY MEMBERS AND OTHERS INTERESTED IN YOUR WELFARE
Please print all names as they would appear on legal documents.

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Telephone _____ E-mail _____

HEALTH CARE AND FINANCIAL DECISIONS

Please print names below.

Health Care Surrogates (Makes health care and living arrangements.)

1 _____ 3 _____

2 _____ 4 _____

Durable Power of Attorney (Makes financial and business decisions.)

1 _____ 3 _____

2 _____ 4 _____

ESTATE PLANNING

Names of those who would inherit the estate

Share of Estate

Personal Representative (Executor) _____

Trustee of Revocable Living Trust _____

HEALTH

Health problems _____

PUBLIC BENEFITS

Has a Medicaid application, **SSI** or **SSD** application or any other application for public benefits been filed?

YES _____ NO _____

If yes, date: _____ Benefits: Approved _____ Denied _____

Government Agency _____

Does anyone in the household receive SSI or SSDI? YES _____ NO _____

Please provide copies of recent notices describing benefits

HOSPICE

Are you being serviced by Hospice? Yes _____ No _____

If yes, name and phone number of Hospice _____

SPECIAL CAREGIVING RESPONSIBILITIES

Special financial or caregiving responsibilities for any family members (aging parents, disabled children or grandchildren, or other relatives). Yes _____ No _____

Name _____ Relationship _____

Date of Birth _____ Receiving What Public Benefits? _____

Name _____ Relationship _____

Date of Birth _____ Receiving What Public Benefits? _____

PETS

Do you have any pets?

Have you made arrangements for their care?

SAFETY DEPOSIT BOX

Name of bank and branch _____

Address _____

City _____ State _____ ZIP _____

Safety Deposit Box # _____

Who is authorized to enter the box? _____

VETERAN INFORMATION

Please complete the following information even if spouse is deceased.

Served in military: Branch _____ Active service in which war? _____

VA benefits (Aid and Attendance) applied for? Yes _____ No _____

Date benefits applied for _____ Date benefits began _____ Amount \$ _____

CAREGIVER OR FRIEND

If this Questionnaire is prepared by someone other than you, please complete the following:

Name _____ Relationship _____

Address _____

Telephone _____ E-mail _____

WHO REFERRED YOU TO OUR OFFICE?

Name _____ Relationship _____

Address _____

Telephone _____ E-mail _____

FINANCIAL ADVISORS

Stockbroker's Name _____

Address _____

Telephone _____ E-mail _____

Accountant or CPA name _____

Address _____

Telephone _____ E-mail _____

HEALTH/MEDICAL INSURANCE

Please provide copies of documentation

Insured name	Company name and address	Monthly premium

LONG TERM CARE POLICIES

Insured name	Company name	Benefit description	Premium Amount

MONTHLY INCOME SUMMARY

List all income amounts – gross and net – per month

Source	Gross	Net
Social Security (Add \$110.50 for gross)		
State Retirement		
Private Pension		
Civil Service		
Railroad Retirement		
IRA Distribution		
Veteran's Benefits		
Interest Income		
Dividend Income		
Alimony		
Rental Income		
Wages		
Other Income		
Total Income	\$	\$

MOTOR VEHICLES

Primary Automobile

Make / Model / Year _____ Owner's name(s) _____

Additional motor vehicles

automobile _____ van _____ recreational vehicle _____ truck _____ boat _____

Describe:

Make / Model / Year	Value	Owner's name(s)
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____
_____	\$ _____	_____

REAL PROPERTY

Please provide copies of documentation

HOMESTEAD

Please provide copy of deed and tax statement

Homestead (your residence) is a house _____ a mobile home _____ a condominium _____

Other, describe _____

If mobile home: Own the lot _____ Rent the lot _____

Address _____ City _____

_____ State _____ Zip Code _____

Names on the deed _____

Is there a mortgage? YES _____ NO _____ Mortgage balance? \$ _____

Tax assessor's value \$ _____

What price would you expect to receive if you sold the home? \$ _____

Date of purchase _____ Purchase Price \$ _____

Homestead exemption on property _____

ADDITIONAL REAL PROPERTY

Please provide copy of deed(s) and written agreements or leases

Property #1 Address _____

This property is: a house _____ a mobile home _____ a condominium _____

Other, describe _____

If mobile home: Own the lot _____ Rent the lot _____

Names on the deed _____

Is there a mortgage? Yes _____ No _____ Mortgage balance? \$ _____

Tax assessor's value \$ _____

Is this property for sale? Yes _____ No _____

What price would you expect to receive if you sold the home? \$ _____

Date of Purchase _____ Purchase price \$ _____

Do you receive rental income? Yes _____ No _____ Monthly rental amount \$ _____

Provide information about additional property on the back of this page.

BURIAL ASSETS

Please provide a copy of burial contract and location and description of cemetery plots

Burial contracts or pre-paid funeral agreement

Contract #1 Name of owner _____

Name of funeral home or insurance company

City _____ State _____

Contract is: revocable _____ irrevocable _____ Contract amount \$ _____

Contract #2 Name of owner _____

Name of funeral home or insurance company

City _____ State _____

Contract is: revocable _____ irrevocable _____ Contract amount \$ _____

Special burial bank account

Name of bank _____

Names on the account _____

Current balance \$ _____

LIFE INSURANCE

Company	Owner	Beneficiary	Face Value	Policy Loan Amount	Cash Value
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$

MONEY DUE TO YOU

(Loans, mortgages, promissory notes)

Loan # 1: Names on the note or mortgage _____

Balance due: \$ _____

Can the mortgage be sold? Yes _____ No _____

Amount you could sell it for? \$ _____

BANK ACCOUNTS

Please provide copies of most recent statements

Use the back of this page for additional bank accounts

Checking #1 Name of Bank _____ Current balance \$ _____

Names on account _____

Checking #2 Name of bank _____ Current balance \$ _____

Names on account _____

Money Market #1 Name of Bank _____ Current balance \$ _____

Names on account _____

Money Market #2 Name of Bank _____ Current balance \$ _____

Names on account _____

Savings #1 Name of Bank _____ Current balance \$ _____

Names on account _____

Savings #2 Name of Bank _____ Current balance \$ _____

Names on account _____

Total all bank accounts \$ _____

CERTIFICATES OF DEPOSIT

Please provide copies of documentation

Use the back of this page for additional CDs

CD #1 Name of bank _____ Amount \$ _____

Names on CD _____ Maturity date _____

CD interest: Paid out _____ Accruing in CD _____

CD #2 Name of bank _____ Amount \$ _____

Names on CD _____ Maturity date _____

CD interest: Paid out _____ Accruing in CD _____

Total all CDs \$ _____

FINANCIAL ACCOUNTS

Please provide copy of most recent statement

Please list all other accounts including brokerage accounts, annuities, retirement accounts, stocks, mutual funds and bonds.

Company	Type (of account)	Beneficiary	Value	Disributions
			\$	\$
			\$	\$

GIFTS TO SOMEONE WITHIN PAST 60 MONTHS

Use the back of the page for additional gifts in the past 60 months.

Please provide information on the gifts made to any person within the last 60 months.

Type of asset = **cash, savings bonds, CD, stock, automobile, real estate, etc.**

Type of asset _____

Date of gift _____ Value of asset on date of gift \$ _____

Type of asset _____

Date of gift _____ Value of asset on date of gift \$ _____

Type of asset _____

Date of gift _____ Value of asset on date of gift \$ _____

Type of asset _____

Date of gift _____ Value of asset on date of gift \$ _____

Type of asset _____

ESTATE PLANNING DOCUMENTS

Document	Date	Location of Original Document
Will		
Trust		
Trust Amendments		
Durable Power of Attorney		
Health Care Surrogate		
Living Will		

Please provide copies of the following documents with the completed Questionnaire:

Last Will and Testament

Trust and Amendments

Durable Power of Attorney

Health Care Surrogate

Living Will

Other estate planning documents for Husband and/or Wife

Driver's license for Husband and/or Wife

If you are unable to supply copies of the above listed items, our office will copy them for you.

After you have completed the Questionnaire, please sign the following statement:

I understand that it is my responsibility to disclose correct and complete information. I hereby attest that the information I have supplied is complete and accurate to the best of my knowledge. I realize that any changes must be reported as soon as possible.

Signature: _____ Date _____

Print Name: _____