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Information For Planning For Arizona Long Term Care And Your Estate (Married Individual)

Please complete the following form to the best of your ability in advance of your appointment with our office so that we will have the necessary information to properly advise you at the time of your appointment. In addition to completing this form, if at all possible please bring with you any documentation that supports the information listed on this form such as:

- Copies of all estate planning documents such as wills, trusts, powers of attorney, durable powers of attorney, health care powers of attorney and/or living wills
- Written documentation of current gross income from income source such as award letters or current check stubs or deposit advice summaries
- Copy of any pre-need burial plan contracts and/or agreements
- Deeds or copies of deeds for real property owned and current mortgage amount
- Copies of life insurance policies and current cash surrender value
- Copies of current statements for all financial accounts (bank and/or investment accounts, IRA, CD’s, etc.)
- Copies of annuity contracts and current cash value
- Copies of military discharge documents (e.g. DD-214)
- Copies of business formation documents and buy-sell agreements
- Copy of birth certificate and Social Security card for person at risk of long term care
- Copy of marriage license
- Copies of unexpired documents showing current immigration status (e.g. resident alien card, naturalization certificate)
- Copy of long term care policies and/or health insurance policies & identification cards including Medicare card
- Any other documents you feel may be helpful in determining the value and title to the applicant’s and spouse’s resources and income

1. **Client Information**: (person who is completing this form)

Client:______________________________

Address:______________________________

____

____

Hm Phone: __________ Wk Phone: __________ Cell Phone: __________

E-Mail Address: ______________________________

Relation to Applicant: ______________________________

2. **Applicant Information**: (person who is at risk of long term care)

Applicant: ______________________________

Date of Birth: __________ Age: __________ SSN: __________

Permanent Address:______________________________

____

____

Hm Phone: __________ Wk Phone: __________ Cell Phone: __________

Present location:______________________________

Phone:______________________________

Type of facility:______________________________

Date entered facility:______________________________

Medicare days used, if nursing home placement:______________________________

Paid for placement through what date:______________________________

U.S. Citizen?: ☐ Yes ☐ No Place of birth ______________________________

If No, please indicate immigration status: ______________________________

Attending interview: ☐ Yes ☐ No

Date of current marriage: ______________________________

Previous Marriages:	**Terminated by:**		Date
______________	☐ Divorce	☐ Death	______________
______________	☐ Divorce	☐ Death	______________

3. **Spouse Information:**

Name: ______________________________

Age:__________ Date of Birth:__________ SSN:__________

Permanent Address if different than applicant:______________________________

____

Present address if different:______________________________

____

Hm Phone: __________ Wk Phone: __________ Cell Phone: __________

Fax: __________ E-Mail Address: ______________________________

U.S. Citizen?: ☐ Yes ☐ No Place of birth ______________________________

If No, please indicate immigration status: ______________________________

Attending interview? ☐ Yes ☐ No

Previous Marriages:	**Terminated by:**		Date
______________	☐ Divorce	☐ Death	______________
______________	☐ Divorce	☐ Death	______________

4. **Children of Current Marriage:**

1) Name:____
Birthdate:____
Address:____
____
Home Phone:__________________Work Phone:__________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse's name: __________________
Attending interview? ☐ Yes ☐ No

2) Name:____
Birthdate:____
Address:____
____
Home Phone:__________________Work Phone:__________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse's name: __________________
Attending interview? ☐ Yes ☐ No

3) Name:____
Birthdate:____
Address:____
____
Home Phone:__________________Work Phone:__________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse's name: __________________
Attending interview? ☐ Yes ☐ No

4) Name:____
Birthdate:____
Address:____
____
Home Phone:__________________Work Phone:__________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse's name: __________________
Attending interview? ☐ Yes ☐ No

5) Name:____
Birthdate:____
Address:____
____
Home Phone:__________________Work Phone:__________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse's name: __________________
Attending interview? ☐ Yes ☐ No

5. Does either the applicant or spouse have any children from a former marriage?
☐ Yes ☐ No. If Yes, please list below:

1) Name:____
Child of: ☐ Applicant ☐ Spouse
Birthdate:____
Address:____
____
Home Phone:____________________Work Phone:____________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse’s name: ____________________
Attending interview? ☐ Yes ☐ No

2) Name:____
Child of: ☐ Applicant ☐ Spouse
Birthdate:____
Address:____
____
Home Phone:____________________Work Phone:____________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse’s name: ____________________
Attending interview? ☐ Yes ☐ No

3) Name:____
Child of: ☐ Applicant ☐ Spouse
Birthdate:____
Address:____
____
Home Phone:____________________Work Phone:____________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse’s name: ____________________
Attending interview? ☐ Yes ☐ No

4) Name:____
Child of: ☐ Applicant ☐ Spouse
Birthdate:____
Address:____
____
Home Phone:____________________Work Phone:____________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse’s name: ____________________
Attending interview? ☐ Yes ☐ No

5) Name:____
Child of: ☐ Applicant ☐ Spouse
Birthdate:____
Address:____

____
Home Phone:____________________Work Phone:____________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse's name: ____________________
Attending interview? ☐ Yes ☐ No

6) Name:____
Child of: ☐ Applicant ☐ Spouse
Birthdate:____
Address:____

____
Home Phone:____________________Work Phone:____________________
Email: ____
Married? ☐ Yes ☐ No If yes, spouse's name: ____________________
Attending interview? ☐ Yes ☐ No

6. If any children are deceased, indicate name(s) and date(s) of death:

____

____

7. <u>Living Grandchildren</u> (If grandchildren are no longer living with their parents, please list the current address and phone number)

Name of Grandchild	**Age**	**Name of Parents**	**Address**	**Phone Number**

8. Does the applicant have any disabled children or grandchildren?
☐ YES ☐ NO

If so, what are their name(s)? ____________________________________

____

If so, what is the type of disability, and has a S.S.A. disability determination been made?____

____

9. Brothers and Sisters

Of Applicant	**Of Spouse**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

9. Legal Documents:

Does the applicant or spouse have any of the following?

		Applicant	**Spouse**
a.	Last will and testament?	☐	☐
b.	Trust/beneficiary of any trust?	☐	☐
c.	Power of Attorney for Financial Decisions?	☐	☐
d.	Power of Attorney for Health Care Decisions?	☐	☐
e.	Living will?	☐	☐
f.	Pre-hospital medical care directive?	☐	☐

10. Medical Planning:

a. Does it appear that the applicant may need long term care in the near future?
☐ Yes ☐ No

b. Has the applicant been hospitalized, in a nursing facility, received community-based long-term care services (ex. adult day care) or in-home medical services for a total of 30 consecutive days? ☐ Yes ☐ No. If Yes, indicate below:

Service Type	**Provider Name**	**Admit Date**	**Discharge Date**
____________	________________	____________	______________
____________	________________	____________	______________
____________	________________	____________	______________
____________	________________	____________	______________
____________	________________	____________	______________

c. Describe the medical condition necessitating long term care and the medical treatments being administered and overall health of applicant in general terms:____
____
____

d. Please describe the applicant's ability to do the following activities (i.e. prompting or hands on assistance necessary):

1. Ambulate____

2. Transfer____
3. Toilet____
4. Eat and prepare food____________________________________
5. Groom____
6. Bathe____
7. Dress____

e. Does the applicant appear to be mentally incapacitated? ☐ Yes ☐ No
If so, what are the indications? ______________________________________
____

f. Does the applicant wander or is he/she aggressive in any way? ☐ Yes ☐ No

g. Is the applicant's spouse at risk of needing long term care? ☐ Yes ☐ No
If so, describe the indications:_______________________________________
____

h. Does the applicant have any of the following health insurance?

	Applicant	Spouse	Policy #	Premium Amount
Medicare coverage (Part A)	☐	☐	__________	_________
Medicare coverage (Part B)	☐	☐	__________	_________
Medigap	☐	☐	__________	_________
Medicare Advantage Plan (HMO)	☐	☐	__________	_________
Long Term Health Care Ins.	☐	☐	__________	_________
Other Insurance (dental, eye)	☐	☐	__________	_________

11. <u>Veteran Status</u>

Veteran? ☐ Applicant ☐ Spouse
Served during war time? ☐ Yes ☐ No. If yes, what war? _________________
Injured while in the service? ☐ Yes ☐ No
Seriously ill while in the service and continuing issues exist? ☐ Yes ☐ No
Mental or physical condition that may be related to service? ☐ Yes ☐ No
Permanently and totally disabled due to military service? ☐ Yes ☐ No

Service History:
Enlistment Date: _________________ to ______________
Separation Date: ___________________________________
Active Duty? ☐ Yes ☐ No
Honorable Discharge? ☐ Yes ☐ No
Branch of the Military: ____________________________
Grade, Rank or Rating: _________________________________
Service Number: _______________________________________

If the applicant or parent was injured while in service:
Were they injured while traveling to/from their military assignment? ☐ Yes ☐ No
If Yes, when and where did the injury occur? _________________________________

Where were they treated (name and address of doctor or hospital if known)?
____
With which agency did they file an incident report?
____

Is the veteran receiving or will they receive retired or retainer pay that is based on military service? ☐ Yes ☐ No

If so, what is the monthly amount paid to them? ______________________________
Is their retirement based on:
☐ Length of service ☐ Disability ☐ Temporary Disability ☐ Retired Status

Will they receive or have they received any of the following benefits:

Lump Sum Readjustment Pay?	☐ Yes ☐ No
Separation Pay?	☐ Yes ☐ No
Special Separation Benefit?	☐ Yes ☐ No
Voluntary Separation Incentive?	☐ Yes ☐ No
Disability Severance Pay?	☐ Yes ☐ No

If Yes, name of disability ____
Other (please specify)____

Is there a representative payee? ☐ Yes ☐ No.
If Yes, who? _________________________.
If No, is anyone applying to become representative payee? ☐ Yes ☐ No.
If Yes, who? _________________________. Application date: _____________

12. <u>Monthly Income:</u>

		<u>Applicant</u>	**<u>Spouse</u>**
a.	Monthly paycheck (gross)	________	________
b.	Monthly paycheck (net)	________	________
c.	Rental income	________	________
d.	Pension/retirement (gross)	________	________
e.	Pension/retirement (net)	________	________
f.	Pension/retirement (gross)	________	________
g.	Pension/retirement (net)	________	________
h.	Social Security Income (gross)	________	________
i.	Social Security Income (net)	________	________
j.	Dividends and interest income, including reinvested dividends and bank account interest	________	________
k.	Disability/unemployment pay	________	________
l.	IRA distributions	________	________
m.	Trust funds	________	________
n.	Annuity	________	________
o.	Note/deed of trust income	________	________
p.	Other _______________________	________	________
TOTAL MONTHLY INCOME:		________	________

Is there a representative payee for Social Security or federal pension? ☐ Yes ☐ No
If Yes, who? _________________________.
If No, is anyone applying to become representative payee? ☐ Yes ☐ No.
If Yes, who? ___________________. Application date: _____________

Are any of the following deducted from the applicant's income?

	Monthly Amount
☐ Health/dental/vision insurance premiums?	______________
☐ Life insurance premiums?	______________
☐ Survivor's pension benefit premium?	______________

13. **<u>Resources:</u> Please list all resources that are titled to either the applicant, spouse or a third party whether or not the applicant or spouse has an ownership interest in the property; if either the applicant's or spouse's name is on the resource, please list it.**

a. **Real Property:**

Address	Names on Deed/Type of Ownership	Market Value

Tax Assessed Value	Balance of Mortgage (if any)	Purchase Price

b. **Household goods and personal effects:**
(Rough estimate)
$______________________________

1) **<u>Valuable Collections:</u>**

Description	Value

c. **Vehicles (including automobiles, mobile homes, golf carts and boats):**

Description	Names on Title	Value	Balance on Loan
______________	______________	$__________	$__________
______________	______________	$__________	$__________
______________	______________	$__________	$__________
______________	______________	$__________	$__________

d. Burial Plots (check if yes and indicate where located)

☐ Applicant ____________________

☐ Spouse ____________________

☐ Immediate Family ____________________

e. Burial Funds or Plans

	Applicant	**Spouse**
Company/mortuary		
Plan number		
Beneficiary		
Current value		
Balance Owed		
Irrevocable?	☐ Yes ☐ No	☐ Yes ☐ No

f. Life Insurance

Company	Owner	Insured Person	Policy Number	Beneficiary	Death Benefit	Cash Value

g. IRA's, 401(k)'s, Keogh, or other retirement plans.

Company	Owner	Type of Account	Account Number	Beneficiary	Cash Value	Current Distribution

h. Annuities

Company	Owner	Policy Number	Beneficiary	Death Benefit	Cash Value

i. **Bank accounts and Money Market accounts**

Bank	Type (i.e. joint checking)	Account Number	Names on Account (Title)	Balance	Interest Rate

j. **Certificates of Deposit**

Bank	Name on Account	Account Number	Balance	Interest Rate	Maturity Date

k. **Promissory Notes or Deeds of Trust, payable to applicant:**

Description	Title	Value
______________________	______________	$__________
______________________	______________	$__________
______________________	______________	$__________

l. **Stocks, bonds, mutual funds held in brokerage account:**

Company	Names on Account	Type of Investment	Account Number	Total Value

m. **Stocks and Mutual Funds (individually owned)**

Description	Names on Certificates	# of Shares	Share Value	Total Value	Monthly Dividend	Purchase Price per Share

n. **Bonds and treasury certificates (individually owned)**

Description	Names on Bonds	Serial Number	Value	Monthly Dividends	Maturity Date

o. **Partnership**

Description	Ownership	Value	Maturity Date

p. **Businesses (corporations, LLCs)**

Name of Entity	Ownership	Value	Maturity Date

Are there any buy/sell agreements for these entities? ☐ Yes ☐ No
If yes, are their life insurance policies covering the business partners/owners?
☐ Yes ☐ No

q. **Other resources:**

Description	Title	Value	Income

14. **<u>Transfer of assets</u>:** Has the applicant transferred any asset to an individual for less than market value within the last five years months, such as large financial gifts ($500.00 or more) to family members or transferring title to assets, including to or from a trust (if so, please describe)?

Property transferred	Value	Transferee	Date Transferred	Amount Received
________________	$______	________________	____________	$______
________________	$______	________________	____________	$______
________________	$______	________________	____________	$______
________________	$______	________________	____________	$______

15. <u>Outstanding Debts:</u>

To Whom Owed:	Amount Due
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________

16. Estimated or current monthly expenses for applicable out-of-home or in-home care for applicant:

Type of Expense	Monthly Amount
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________
______________________________	$_______________

17. Other estimated monthly expenses, if applicable

Type of Expense	Monthly Amount
Mortgage or rent	$_______________
APS/electric	$_______________
Gas/utility	$_______________
Phone	$_______________
Phone	$_______________
Water	$_______________
Food	$_______________
Postage	$_______________
Car Insurance	$_______________
Medical and dental insurance premiums	$_______________
Prescriptions	$_______________
Gas for auto	$_______________
Property taxes	$_______________
Home insurance	$_______________
Clothing	$_______________
Entertainment	$_______________
Life insurance premiums	$_______________
Gifts/donations	$_______________
Newspaper/magazines	$_______________
Cable T.V.	$_______________
Automobile maintenance/repair	$_______________
Home maintenance/repair	$_______________
Vacations	$_______________

Unreimbursed medical/dental expenses		$________________
Income Taxes		$________________
Miscellaneous (supplies, etc.)		$________________
Credit Card Debt		$________________
Hair		$________________
______________________________		$________________
______________________________		$________________
	TOTAL	**$________________**

18. Does the applicant currently have a financial advisor? ☐ Yes ☐ No.
If Yes, please list their name and address:____
____

19. Does the applicant currently have an insurance agent for long term care insurance or have you contacted one? ☐ Yes ☐ No.
If Yes, please list their name and address: ______________________________________
____

20. Does the applicant currently have an accountant? ☐ Yes ☐ No.
If Yes, please list their name and address:____
____

21. Does the applicant currently have a physician? ☐ Yes ☐ No.
If Yes, please list physician's name and address:___________________________________
____

22. Is the applicant expecting any inheritances in the near future? ☐ Yes ☐ No.
If Yes, how much and from whom?____

23. Is the applicant entitled to and/or receiving benefits for long term medical care through the Veterans Administration? ☐ Yes ☐ No.
If Yes, please describe:____

24. If the applicant currently enrolled in a prescription drug plan? ☐ Yes ☐ No.
If so, what is the name of the plan? (Please bring copy of card and description of coverage)

25. If the applicant is not enrolled in Medicare Part D and have prescription drug coverage, have you contacted their health insurance company to verify whether they have "creditable coverage"? ☐ Yes ☐ No

If the applicant does not have prescription drug coverage or have it but are dissatisfied and want to know if enrolling in Medicare Part D could save them money on prescription drug costs, please let us know so we can help you determine whether enrolling in Medicare Part D might save the applicant money, and if so, refer you to an agency who will help you select a plan under Medicare Part D that will meet the applicant's needs.

Verification

I have provided complete and accurate financial information to the Law Offices of Chester B. McLaughlin, P.C. for the purposes of long term care planning. I understand that the long term care advice, ALTCS application, and terms of the fee agreement will be based upon the information provided in this questionnaire. I understand that any inaccurate or omitted financial information could result in inappropriate legal advice, denial of the ALTCS application, and revision of the terms of the fee agreement.

Date:_______________

____
Client