



Chester McLaughlin

E L D E R L A W

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Information For Planning For
Arizona Long Term Care And Your Estate
(Single 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 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 annuity contracts and current cash value
- ◆ Copies of military discharge documents for applicant, deceased spouse and/or parent (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
- ◆ 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 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: _____

Home Phone: _____ Work Phone: _____
Email Address: _____
Present location: _____
Phone: _____
Type of facility: _____
Date entered facility: _____
Medicare days used, if nursing home placement: _____
Paid for placement through what date: _____
Attending interview: Yes No
U.S. Citizen?: Yes No Place of birth _____
If No, please indicate immigration status: _____

Previous Marriages:

Terminated by:

Date

_____ Divorce Death _____
_____ Divorce Death _____

3. **Children:**

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

6) Name: _____
 Birthdate: _____
 Address: _____

 Home Phone: _____ Work Phone: _____
 Email: _____
 Married? Yes No If yes, spouse's name: _____
 Attending interview? Yes No

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

5. **Living Grandchildren** (If grandchildren are no longer living with their parents, please list the current address and phone number)

<u>Name of Grandchild</u>	<u>Age</u>	<u>Name of Parents</u>	<u>Address</u>	<u>Phone Number</u>

6. 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? _____

7. Brothers and Sisters

Name

Address and Phone Number

8. Legal Documents:

Does the applicant have any of the following?

- a. Last will and testament? Yes No
- b. Trust/beneficiary of any trust? Yes No
- c. Power of Attorney for Financial Decisions? Yes No
- d. Power of Attorney for Health Care Decisions? Yes No
- e. Living will? Yes No
- f. Pre-hospital medical care directive? Yes No

9. Medical Planning:

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

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

c. 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 _____

d. Does the applicant appear to be mentally incapacitated? Yes No
If so, what are the indications? _____

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

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

	Coverage	Policy #	Premium Amount
Medicare coverage (Part A)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Medicare coverage (Part B)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Medigap	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Medicare Advantage Plan (HMO)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Long Term Health Care Ins.	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other Insurance (dental, eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

10. Veteran Status

Is the applicant a veteran? Yes No

If the applicant's deceased spouse a veteran? Yes No

If the applicant is a minor child or adult disabled since childhood, is either parent a veteran? Yes No. If so, which parent? Mother Father

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 applicant receiving or will 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: _____

11. Monthly Income:

	<u>Gross</u>	<u>Net</u>
a. Monthly paycheck	_____	_____
b. Rental income	_____	_____
c. Pension and retirement	_____	_____
d. Social Security Income	_____	_____
e. Dividends and interest income, including reinvested dividends and bank account interest	_____	_____
f. Disability and unemployment pay	_____	_____
g. IRA distributions	_____	_____
h. Trust funds	_____	_____
i. Annuity	_____	_____
k. Note/deed of trust income	_____	_____
l. 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? _____

12. Resources:

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) **Valuable Collections:**

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 _____
 Deceased Spouse _____
 Immediate Family _____

e. Burial Funds or Plans

Applicant

Company/mortuary _____
 Plan number _____
 Beneficiary _____
 Current value _____
 Balance Owed _____
 Irrevocable? 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

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

Property transferred	Value	Transferee	Date Transferred	Amount Received
_____	\$ _____	_____	_____	\$ _____
_____	\$ _____	_____	_____	\$ _____
_____	\$ _____	_____	_____	\$ _____
_____	\$ _____	_____	_____	\$ _____

14. Outstanding Debts:

To Whom Owed:	Amount Due
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

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

Type of Expense	Monthly Amount
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

16. 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	\$ _____

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

18. 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: _____

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

20. Does the applicant currently have a physician? Yes No.
 If Yes, please list physician's name and address: _____

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

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

23. Are you 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)

24. If you are not enrolled in Medicare Part D and have prescription drug coverage, have you contacted your health insurance company to verify if you have "creditable coverage"?
 Yes No

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