

## Long Term Care Initial Intake Questionnaire

The information contained in the following questionnaire is essential for us to know so that we may properly plan for you. Please complete the form to the best of your ability. All of the information which you provide will remain a part of your client file and is confidential. Please note the term "client" generally refers to the ill or incapacitated individual.

Today's Date: \_\_\_\_\_

Name of Individual completing this form: \_\_\_\_\_

Relationship to Client (if not completed by Client): \_\_\_\_\_

Names of other persons attending this meeting: \_\_\_\_\_

Who referred you to our firm? \_\_\_\_\_

Which Attorney were you referred to? Edwin Boyer\_\_ Mary Alice Jackson\_\_ Teresa Bowman\_\_  
Andrew Boyer\_\_ Boyer & Jackson, P.A. \_\_

Have you or anyone in your family been to our firm before? If so, when? \_\_\_\_\_

Have you spoken to another attorney about this same matter? If so, who? \_\_\_\_\_

Name of person to be billed? \_\_\_\_\_

Preferred Method of Written Communication Mail ( ) E-mail ( ) Fax ( )

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**Client's Name:** \_\_\_\_\_

Currently living: Home \_\_\_\_\_ Nursing Home \_\_\_\_\_ ALF \_\_\_\_\_ Date of admission \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Home or facility Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Home address if living in facility: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

US Citizen ( ) Yes ( ) No Place of Birth: \_\_\_\_\_ Veteran ( ) Yes ( ) No

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**Spouse's Name:** \_\_\_\_\_

If deceased, date of death: \_\_\_\_\_

Currently living: Home \_\_\_\_\_ Nursing Home or ALF \_\_\_\_\_ Date of admission \_\_\_\_\_

Home or facility Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home address if living in facility: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

US Citizen ( ) Yes ( ) No Place of Birth: \_\_\_\_\_ Veteran ( ) Yes ( ) No

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**CONTACT PERSON - If other than spouse**

Contact Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone No.'s: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Alternate E-mail address: \_\_\_\_\_

**GENERAL INFORMATION ABOUT THE CLIENT**

Are you currently \_\_\_\_\_ married \_\_\_\_\_ widowed \_\_\_\_\_ divorced \_\_\_\_\_ single

Number of prior marriages? \_\_\_\_\_ ( ) husband ( ) wife

Date of current marriage. \_\_\_\_\_

Is there a prenuptial agreement? \_\_\_\_\_ ( ) Yes ( ) No

Do you own your home? \_\_\_\_\_ If yes, is there a mortgage? \_\_\_\_\_

Whose names are listed on the deed to the homestead property? \_\_\_\_\_

Do you have investment/rental property or a vacation home? \_\_\_\_\_

How many children do you have? \_\_\_\_\_

Are all the children of this marriage? \_\_\_\_\_ ( ) Yes ( ) No

Is anyone in the client's family disabled? If so, whom: \_\_\_\_\_

Current/Previous Occupation? Husband: \_\_\_\_\_ Wife: \_\_\_\_\_

Please list the names, addresses and telephone numbers of all children and indicate whether they are the husband's children (H), the wife's children (W), or children of both (B). Please note if any of the children have died leaving children of their own (grandchildren).

Name	Address	Telephone number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you enrolled in a Medicare D program? If so, what is the name of the Program \_\_\_\_\_

Coverage for Client \_\_\_\_\_ Spouse \_\_\_\_\_ Monthly Premium\$ \_\_\_\_\_

Medical Supplemental Insurance Carrier \_\_\_\_\_

Coverage for Client \_\_\_\_\_ Spouse \_\_\_\_\_

Policy Number \_\_\_\_\_ Monthly Premium \$ \_\_\_\_\_

Long Term Health Care Insurance Carrier \_\_\_\_\_

Coverage for Client \_\_\_\_\_ Spouse \_\_\_\_\_ Monthly Premium \$ \_\_\_\_\_

Benefit amount per day: \_\_\_\_\_ Elimination period: \_\_\_\_\_ Coverage period in years: \_\_\_\_\_

Do you have a Will? yes \_\_\_ no \_\_\_ If yes, what is the date of the Will? \_\_\_\_\_

Where is the will kept? \_\_\_\_\_ Who is the Personal Representative? \_\_\_\_\_

Who prepared the document for you? \_\_\_\_\_

Did you create a Revocable Living Trust? yes \_\_\_ no \_\_\_ If yes, date of the Trust? \_\_\_\_\_

Where is the Trust kept? \_\_\_\_\_ Who is/are the Trustee(s)? \_\_\_\_\_

Who prepared the document for you? \_\_\_\_\_

Are you the beneficiary of trust agreement(s) created by someone else? yes \_\_\_ no \_\_\_ Please attach a copy of the trust.

If yes, who established the trust? \_\_\_\_\_ On what date? \_\_\_\_\_

Do you have a Health Care Directive/Living Will? Yes \_\_\_ No \_\_\_ If yes, what is the date? \_\_\_\_\_

Who have you named as your health care decision maker(s)? \_\_\_\_\_

Who prepared the document for you? \_\_\_\_\_

Who has current possession of the document? \_\_\_\_\_

Do you have a Durable Power of Attorney? Yes \_\_\_ No \_\_\_ If yes, what is the date \_\_\_\_\_

Who is your designated as your Agent(s)? \_\_\_\_\_

Who prepared the document for you? \_\_\_\_\_

Who has current possession of the document? \_\_\_\_\_

**GIFTS TO SOMEONE ELSE OTHER THAN A SPOUSE WITHIN THE LAST 60 MONTHS**

Type of Asset: \_\_\_\_\_ Date of gift: \_\_\_\_\_ Amount: \_\_\_\_\_  
 Type of Asset: \_\_\_\_\_ Date of gift: \_\_\_\_\_ Amount: \_\_\_\_\_  
 Type of Asset: \_\_\_\_\_ Date of gift: \_\_\_\_\_ Amount: \_\_\_\_\_

**INCOME:** Please list amounts of **gross (before taxes)** monthly income which apply to you and your spouse.  
 Please bring documentation of income to initial meeting.

<b><u>CLIENT</u></b>		<b><u>SPOUSE</u></b>	
Work Earnings	_____	Work Earnings	_____
SS Retirement	_____	SS Retirement	_____
SS Disability	_____	SS Disability	_____
Veterans benefit	_____	Veterans benefit	_____
Private Pension	_____	Private Pension	_____
Public Employ. Pension	_____	Public Employ. Pension	_____
RR Retirement	_____	RR Retirement	_____
Rental Income	_____	Rental Income	_____
Annuity	_____	Annuity	_____
Interest & Dividends	_____	Interest & Dividends	_____
IRA income	_____	IRA income	_____
Other	_____	Other	_____

**ASSETS:** Please give an estimated value of the following assets excluding your home and car.

	Client	Spouse	Joint
Checking & savings	_____	_____	_____
Certificates of deposit	_____	_____	_____
Stocks, bonds, mutual funds	_____	_____	_____
Annuities	_____	_____	_____
IRA's	_____	_____	_____
Savings bonds	_____	_____	_____
Life insurance cash value	_____	_____	_____
Non-homestead real estate	_____	_____	_____
Other	_____	_____	_____

What are your current expenses per month?

Housing Expenses (include mortgage, maintenance and condo fees, insurance): \_\_\_\_\_

Utilities: \_\_\_\_\_

Medical Expenses (including pharmacy): \_\_\_\_\_

What is current mental and physical health of the client: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is the current mental and physical health of the spouse: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you anticipate the need to place client in a long term care facility within the next 12 months? If so, when?

\_\_\_\_\_

Do you have professional advisors?

	Name	Address	Phone
CPA	_____	_____	_____
Insurance Advisor	_____	_____	_____
Financial Advisor	_____	_____	_____
Banker	_____	_____	_____
Spiritual Advisor	_____	_____	_____

What is your primary goal in seeking legal

advice? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional information you feel we should know about the client and/or family:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_