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Date: _____

LONG TERM PLANNING QUESTIONNAIRE
CONFIDENTIAL INFORMATION

Instructions | Please print clearly

Please complete this form to the best of your ability so we may provide the most informative consultation. Print additional pages if needed.

If someone other than the person seeking services is completing this form, please provide:

Name: _____

Relationship to the person seeking services: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INFORMATION ABOUT THE PERSON SEEKING SERVICES

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ Marital Status: _____

Employer: _____ Retirement Date: _____

Employer Address: _____

City, State, Zip: _____

U.S. Citizen: Yes ☐ No ☐

Has the person ever applied for any type of government assistance/benefits? Yes ☐ No ☐

If yes, list the type and date of application (i.e. Medicaid, Veterans' Benefits, SSI, SSDI, etc.):

_____

Has the person had any contact with the Family Support Division (Medicaid)? Yes ☐ No ☐

If yes, please provide date and contact: _____

_____

Has the person ever had a stay in a hospital/rehab/nursing home for a period of at least 30 consecutive days? (This can be a combination of hospital/rehab/nursing home or just hospital or just rehab/nursing home stays for a continuous 30-day period. Please consider any 30-day stay during his/her lifetime.) Yes ☐ No ☐

If yes, please indicate date: _____

INFORMATION ABOUT THE PERSON SEEKING SERVICES

Is the person currently residing in a facility? Yes ☐ No ☐

Name of facility _____

Address: _____

Level of care: _____ Type of facility: _____

Date of admission: _____ Funding source(s): _____

Is there a Social Worker at the facility with whom the person has been working? Yes ☐ No ☐

FAMILY INFORMATION

Spouse
If deceased, only name and date of death are needed

Spouse #I Name: _____

Birthdate: _____

If deceased, date of death: _____ If divorced, date of divorce: _____

Spouse #2 Name: _____

Birthdate: _____

If deceased, date of death: _____ If divorced, date of divorce: _____

Children
If deceased, only name and date of death are needed

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____

If deceased, date of death: _____

FAMILY INFORMATION

Children
If deceased, only name and date of death are needed

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____

If deceased, date of death: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____

If deceased, date of death: _____

Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____

If deceased, date of death: _____

FAMILY INFORMATION

Children

Do any of the children have special needs?

Child's Name: _____ Special Need: _____

Child's Name: _____ Special Need: _____

Child's Name: _____ Special Need: _____

Does the person have a Special Needs Trust for his/her child(ren)? Yes ☐ No ☐

Do any family member(s) currently live in the home? Yes ☐ No ☐

If yes, does the person provide support to that family member(s)? Yes ☐ No ☐

Describe the circumstances and reason for the arrangement. Explain how the situation is handled financially. Provide name(s), relationship to the Party, and the amount of monthly support:

_____

_____

_____

REAL ESTATE

Home Address: _____

Name(s) on Deed: _____

Date of Purchase: _____ Purchase Price: $ _____

Mortgage Balance: $ _____ Market Value: $ _____

Beneficiary Deed: _____

Other Real Estate Address: _____

Name(s) on Deed: _____

Date of Purchase: _____ Purchase Price: $ _____

Mortgage Balance: $ _____ Market Value: $ _____

Beneficiary Deed: _____

VEHICLES

Make/Year: _____

Name(s) on Title: _____

Loan Balance: $ _____ Market Value: $ _____

Transfer on Death: _____

Make/Year: _____

Name(s) on title: _____

Loan Balance: $ _____ Market Value: $ _____

Transfer on Death: _____

ACCOUNTS & INVESTMENTS

Checking

Financial Institution: _____ Account # (last four digits only): _____

Name(s) on Account: _____

Balance: $ _____

Payable on Death Beneficiaries: _____

Financial Institution: _____ Account # (last four digits only): _____

Name(s) on Account: _____

Balance: $ _____

Payable on Death Beneficiaries: _____

Savings

Financial Institution: _____ Account # (last four digits only): _____

Name(s) on Account: _____

Balance: $ _____

Financial Institution: _____ Account # (last four digits only): _____

Name(s) on Account: _____

Balance: $ _____

ACCOUNTS & INVESTMENTS

Other

Financial Institution: _____ Account # (last four digits only): _____

Name(s) on Account: _____

Value: $ _____

Financial Institution: _____ Account # (last four digits only): _____

Name(s) on Account: _____

Value: $ _____

Financial Institution: _____ Account Type: _____

Name(s) on Account: _____

Value: $ _____

Financial Institution: _____ Account Type: _____

Name(s) on Account: _____

Value: $ _____

Financial Institution: _____ Account Type: _____

Name(s) on Account: _____

Value: $ _____

Financial Institution: _____ Account Type: _____

Name(s) on Account: _____

Value: $ _____

Financial Institution: _____ Account Type: _____

Name(s) on Account: _____

Value: $ _____

INSURANCE

Life

Company: _____ Policy # (last four digits only): _____ Whole ☐ Term ☐

Policy Owner: _____

Beneficiary: _____ Contingent Beneficiary: _____

Value: $ _____ Cash Surrender Value: $ _____

Death Benefit: $ _____

Company: _____ Policy # (last four digits only): _____ Whole ☐ Term ☐

Policy Owner: _____

Beneficiary: _____ Contingent Beneficiary: _____

Value: $ _____ Cash Surrender Value: $ _____

Death Benefit: $ _____

Supplemental
Include
Long-Term
Care Policies

Company: _____ Policy # (last four digits only): _____

Policy Owner: _____ Beneficiary: _____

Value: $ _____ Duration: _____

Company: _____ Policy # (last four digits only): _____

Policy Owner: _____ Beneficiary: _____

Value: $ _____ Duration: _____

INSURANCE

Health Spouse #1

Check all that apply:

- ☐ Medicare
- ☐ Medicare Supplemental Insurance

Company: _____ Monthly Premium: $ _____

How is the premium paid? _____

Company: _____ Monthly Premium: $ _____

How is the premium paid? _____

Health Spouse #2

Check all that apply:

- ☐ Medicare
- ☐ Medicare Supplemental Insurance

Company: _____ Monthly Premium: $ _____

How is the premium paid? _____

Company: _____ Monthly Premium: $ _____

How is the premium paid? _____

PREPAID FUNERAL

Spouse #1

Funeral Home: _____

Is this plan irrevocable? Yes ☐ No ☐

Policy Owner: _____ Beneficiary: _____

Spouse #2

Funeral Home: _____

Is this plan irrevocable? Yes ☐ No ☐

Policy Owner: _____ Beneficiary: _____

OTHER ASSETS

Is the person the beneficiary or grantor of any Trust: Yes ☐ No ☐

If yes, please attach a photocopy of a signed version if available or provide any details you can regarding the terms and conditions, identity of the current trustee, amount of principal, etc.

_____

_____

During the last 60 months has the person made any gifts ($1,000 or more in value), placed property into a trust, transferred real estate or other property for less than fair market value, or removed or added names to join accounts?

Yes ☐ No ☐

If yes, please list each action and explain when and why the transfer was made:

_____

_____

_____

MONTHLY INCOME

Spouse #1

Employment: _____ $ _____ /month

Social Security Retirement: _____ $ _____ /month

Social Security Disability: _____ $ _____ /month

Supplemental Security Income: _____ $ _____ /month

Veteran's Benefits: _____ $ _____ /month

Private Pension: _____ $ _____ /month

Annuity: _____ $ _____ /month

Other Income: _____ $ _____ /month

To the extent not already noted above, please describe any significant changes that you anticipate occurring with respect to your financial or personal situation. _____

_____

MONTHLY INCOME

Spouse #2

Employment: _____ $ _____ /month

Social Security Retirement: _____ $ _____ /month

Social Security Disability: _____ $ _____ /month

Supplemental Security Income: _____ $ _____ /month

Veteran's Benefits: _____ $ _____ /month

Private Pension: _____ $ _____ /month

Annuity: _____ $ _____ /month

Other Income: _____ $ _____ /month

To the extent not already noted above, please describe any significant changes that you anticipate occurring with respect to your financial or personal situation. _____

_____

ESTATE PLANNING DOCUMENT INFORMATION

The person currently has a:

Will Yes ☐ No ☐

Trust Yes ☐ No ☐

Power of Attorney for finances Yes ☐ No ☐

Power of Attorney for health care decisions Yes ☐ No ☐

Gift ☐ Inheritance ☐ Lawsuit ☐ Other ☐ Approximately how much? _____

VETERAN'S SERVICE INFORMATION

Veteran's Name: _____

Birthdate: _____

City, State, and Country where Veteran was born: _____

Marital Status: _____

Location of marriage, if applicable (city and state): _____

Location of divorce, if applicable (city and state): _____

Branch of Service: _____

Date of Service (start and end dates): _____

VA File # (last four digits only): _____ If Veteran is deceased, date of death: _____