

Farrell & Pak PLLC

Long-Term Care & Estate Planning Questionnaire

Questionnaire completed by _____
 Relationship Husband Wife _____ of _____

Conference is scheduled on _____ Who will attend?

Full Name	
Date of Birth	Citizenship <input type="checkbox"/> U.S. <input type="checkbox"/> Resident Alien <input type="checkbox"/> Neither
SSN:	
Home Address	Mailing address (if different)
County	Email
Phone (Best)	Phone (Other)
Living Arrangements <input type="checkbox"/> Own Home <input type="checkbox"/> Rent-House/Apt. <input type="checkbox"/> Rent-Assisted Living <input type="checkbox"/> No Rent-Home of _____ <input type="checkbox"/> Nursing Facility _____ _____ Who else lives there(if not Nursing Home or ALF)	Marital History <input type="checkbox"/> Never married <input type="checkbox"/> Previously married -- Name of most recent spouse _____ Date of Marriage _____ Marriage ended in <input type="checkbox"/> Divorce Date _____ County _____ <input type="checkbox"/> Death Date of Death _____

Nursing Home/Hospital Information (if applicable)

Date In	Date Out	Name of Facility (& place if not Austin)	Nursing Home	Hosp	Rehab

Is Medicare paying for your nursing home stay now? Yes No

Who provides significant assistance for you now? _____

Future care needs Hospital Nursing Home ALF Home Care 24/7 Home Care ___hrs/week None

Life Expectancy No known limit Less than 6 months, according to physician Uncertain

Your Health

Diagnoses _____

Medication(s) _____

Personal care you are getting now _____

Activities you need help with (check all that apply)

- Dressing Bathing Toileting Transferring Eating
 Continence Medications Walking

Mental status (check all that apply, even if only from time to time)

- Recognize friends & family Yes No Sometimes
 Can describe own money & property Yes No Sometimes
 Can name all close family members Yes No Sometimes

Comments _____

Attorney use only

- Medicaid "medical necessity"? Yes No Uncertain
 Capacity to sign POA's? Yes No Uncertain
 Capacity to sign will? Yes No Uncertain
 Capacity to make gifts? Yes No Uncertain

Your Medical Expenses

Medical Expense	Cost/Month
<input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Home Care <input type="checkbox"/> Sitter	
Medications (out of pocket expense)	
<input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D	
<input type="checkbox"/> Medicare Supplement Insurance Company or Medicare Advantage Plan Name _____	
<input type="checkbox"/> Other Medical Insurance Type _____ Company _____	
<input type="checkbox"/> Long Term Care Insurance	
Other out of pocket Medical Expenses	

Your Family

Do you have one or more living children? Yes No

Do you have any grandchildren who are children of a deceased child of yours? Yes No

*List below your children. If a child of yours has died, also list his or her children (your grandchildren)
If you have no children, list your closest family or friends and the relationship.*

Child One

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Husband Wife Both

Communication Authorized with this Child*? Yes No

Child Two

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Husband Wife Both

Communication Authorized with this Child*? Yes No

Child Three

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Husband Wife Both

Communication Authorized with this Child*? Yes No

Child Four

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Husband Wife Both

Communication Authorized with this Child*? Yes No

Child Five

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Husband Wife Both

Communication Authorized with this Child*? Yes No

<i>Attorney Notes re family and other sources of support, conflict or difficulty</i> _____

**if you select "yes," none of your communications with us will be confidential with regard to that child and you will be waiving attorney-client privilege with regard to any civil or criminal cases*

Homestead Information Concerning Your Residence, If Owned By You

Location _____

Title is in the name of _____

Market value \$ _____ **Tax appraised value \$** _____

Mortgage balance Nothing (paid off) Presently owe \$ _____

Who lives there now? Husband Wife Both Other _____

Does your unmarried son or daughter live there? Yes No

Does your son or daughter who has provided care for you for 2 years live there? Yes No

Other information concerning your residence that may be important _____

Non-Homestead Real Property #1

Location _____

Oil, Gas, or Mineral Royalty? **Leased?** Yes No **Producing?** Yes No
Income per month \$ _____ Acquired by Purchase Inheritance Gift

On or about _____

Title is in the name of _____

Market value \$ _____ **Tax appraised value \$** _____

Mortgage Nothing (paid off) Presently owe \$ _____

Who lives there now? Husband Wife Both Tenant who pays no rent

Tenant who pays rent of \$ _____ / month Tenant is family member? _____

Non-Homestead Real Property #2

Location _____

Oil, Gas, or Mineral Royalty? **Leased?** Yes No **Producing?** Yes No
Income per month \$ _____ Acquired by Purchase Inheritance Gift

On or about _____

Title is in the name of _____

Market value \$ _____ **Tax appraised value \$** _____

Mortgage Nothing (paid off) Presently owe \$ _____

Who lives there now? Husband Wife Both Tenant who pays no rent

Tenant who pays rent of \$ _____ / month Tenant is family member? _____

TOTAL REAL PROPERTY: \$ _____

Assets

Description	Title ¹	Most Recent Market Value	Debt secured by this asset	Beneficiary at Death (other than by will) if any
Most Valuable Vehicle ²				
Vehicle 2				
Vehicle 3				
Gravesite/Marker				
Prepaid Funeral Contracts				
Prepaid Funeral Contracts				
Household Goods held for investment value rather than personal use; Insured?				
Bank & Credit Union accounts (checking, savings, CDs, money market funds, other cash equiv.)				
Brokerage Accounts and other non-retirement (non-tax-qualified) investment accounts				
“Non-qualified” Annuities				
Retirement Accounts IRA, 401(k), 403(b), Qualified Annuities				
Certificated Shares, Bonds, Private Business interests, contract rights, notes receivable, etc.				

¹ “H” for Husband, “W” for Wife, “HW” for both; Leave blank if uncertain. Note if anyone else is owner.

² Enter year, make, and model for all vehicles, including all motorcycles, boats, trailers, RVs, etc..

Other Assets, Rights, Expected Receipts/refunds				
Life Insurance Policies insurance company name; Death benefit amount	Insured Life & Policy Owner	Cash Surrender value	Loan Amount	Death Benefit & Beneficiaries
Safe Deposit Box & Contents	Contents			
TOTAL ASSETS				

Your Debts

How many credit cards do you have? _____ Payments current? Yes No

Average charges to credit cards/month \$ _____ Usual total expenses/month \$ _____

Description	Amount
Homestead Debt	
Other Secured Debt	
Unsecured Debt	
Unsecured Debt	
<i>Attorney Use only</i>	
<i>Total debt</i>	
<i>Net(after debts) countable resources</i>	

Attorney Notes re Closed Accounts

Trusts & Transfers

Are you beneficiary of a trust? Yes No

Transferred assets to a trust? Yes No

Anticipate an inheritance? Yes No

Received an inheritance? Yes No

(If Yes, be sure anything you still own is listed among your other assets above.)

Have you transferred cash or anything else, for less than fair market value, in last 5 years?

Yes No If Yes Recipient _____

Asset description _____

Date _____ Value \$ _____

Received in return Nothing (Gift) \$ _____ Cash Other _____

Was the transfer motivated, at least in part, by need for Medicaid eligibility? Yes No

If No, explain purpose(s) of transfer

Attorney Notes re Transfers

Military Service

Have you, your spouse or deceased child(ren) ever been in the armed forces? YES NO

Veteran's Name	Service No./Branch	Dates of Service	Type of Discharge*
			H <input type="checkbox"/> G <input type="checkbox"/> D <input type="checkbox"/>
			H <input type="checkbox"/> G <input type="checkbox"/> D <input type="checkbox"/>
			H <input type="checkbox"/> G <input type="checkbox"/> D <input type="checkbox"/>

* H=Honorable G=General D=Dishonorable

Your Income

Please indicate monthly income .

FIXED INCOME	Amount
Social Security Net Monthly Payment	
Medicare Part B premium	
Medicare Part D premium	
SSI	
VA	
Railroad Retirement	
Civil Service Annuities	
Pension	
Annuities	
Other Retirement	
Other Fixed Income	
<i>Attorney use only</i>	<i>Total fixed</i>
VARIABLE INCOME	
Gross Earned Income	
Interest	
Dividends	
Rental/Notes	
Oil & Gas	
Farm Income	
Other Income	
<i>Attorney use only</i>	<i>Total variable</i>
	<i>Total income</i>
POSSIBLE DEDUCTIONS	
Taxes withheld from income (monthly)	
Monthly health insurance premium	

Questions concerning legal documents

Document	Do you have this document?
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Durable Power of Attorney (Financial)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Power of Attorney for Health Care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Directive to Physicians (Living Will)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Court Appointed Guardianship of <input type="checkbox"/> Estate <input type="checkbox"/> Person	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Living (Revocable) Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Documents funding Living Trust (deeds, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain

<i>Attorney use only--</i> Notes concerning legal documents

<i>Attorney use only</i>
Goals of client
<input type="checkbox"/> Acquire the best possible long term care, within his/her financial ability
<input type="checkbox"/> Keep in the family certain assets _____
<input type="checkbox"/> Acquire effective wills and powers of attorney
<input type="checkbox"/> Protect a child or other person with a disability
<input type="checkbox"/> Other _____