

Farrell & Johnson PLLC Long-Term Care & Estate Planning Questionnaire

Questionnaire completed by _____ Conference date: _____

Spouse A	Spouse B
Full Name	Full Name
Date of Birth	Date of Birth
SSN:	SSN:
Home Address	Home Address
County	County
Mailing address if different	Mailing address if different
Phone	Phone
Email	Email
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)	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)
<input type="checkbox"/> U.S <input type="checkbox"/> Resident Alien <input type="checkbox"/> Neither	Citizenship <input type="checkbox"/> U.S. <input type="checkbox"/> Resident Alien <input type="checkbox"/> Neither
Marital History <input type="checkbox"/> Date of Marriage _____ <input type="checkbox"/> No previous marriage <input type="checkbox"/> Previously married -- Name of previous spouse _____ Previous marriage ended in <input type="checkbox"/> Divorce Date _____ County _____ <input type="checkbox"/> Death Date of Death _____	Marital History <input type="checkbox"/> Date of Marriage _____ <input type="checkbox"/> No previous marriage <input type="checkbox"/> Previously married -- Name of previous spouse _____ Previous marriage ended in <input type="checkbox"/> Divorce Date _____ County _____ <input type="checkbox"/> Death Date of Death _____

Your Family

Do you (or either of you) have one or more living children (biological or adopted) ? Yes No

How many total children have you ever had? _____

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? Spouse A Spouse B Both

Communication Authorized with this Child*? Yes No

Child Two

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Spouse A Spouse B Both

Communication Authorized with this Child*? Yes No

Child Three

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Spouse A Spouse B Both

Communication Authorized with this Child*? Yes No

Child Four

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Spouse A Spouse B Both

Communication Authorized with this Child*? Yes No

Child Five

Name _____

Tel _____ Email _____

Address _____

Age _____ Married? Yes No Disabled? Yes No Uncertain

Whose Child? Spouse A Spouse B Both

Communication Authorized with this Child*? Yes No

**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.*

Spouse A's Nursing Home/Hospital History

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

“Snapshot date*” for Spouse A if any _____

Who provides significant assistance for Spouse A 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

Spouse B's Nursing Home/Hospital History

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

“Snapshot date*” for Spouse B if any _____

Who provides significant assistance for Spouse B 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

*“Snapshot Date” First day of the first month when one spouse goes into a “medical institution” and stays at least 30 days, when the Medicaid program takes a “snapshot” of all assets of both spouses. “Medical institution” is a hospital, nursing home or rehabilitation facility (but not an Assisted Living Facility); time continues to run if transferred from one medical institution directly to another.

Your Health

<p>Physical/Mental Condition of Spouse A</p> <p>Diagnoses _____</p> <p>_____</p> <p>_____</p> <p>Medication(s) _____</p> <p>_____</p> <p>Personal care you are getting now _____</p> <p>_____</p> <p>_____</p>	<p>Physical/Mental Condition of Spouse B</p> <p>Diagnoses _____</p> <p>_____</p> <p>_____</p> <p>Medication(s) _____</p> <p>_____</p> <p>Personal care you are getting now _____</p> <p>_____</p> <p>_____</p>
<p>Activities you need help with</p> <p><input type="checkbox"/>Dressing <input type="checkbox"/>Bathing <input type="checkbox"/>Toileting <input type="checkbox"/> Transferring</p> <p><input type="checkbox"/>Walking <input type="checkbox"/> Eating <input type="checkbox"/> Medication <input type="checkbox"/> Continance</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Mental status (check all that apply, even if only from time to time)</p> <p>Recognize friends & family <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Sometimes</p> <p>Can describe own property <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Sometimes</p> <p>Can name all family members <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Sometimes</p> <p>Comments _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Activities you need help with</p> <p><input type="checkbox"/>Dressing <input type="checkbox"/>Bathing <input type="checkbox"/>Toileting <input type="checkbox"/> Transferring</p> <p><input type="checkbox"/>Walking <input type="checkbox"/> Eating <input type="checkbox"/> Medication <input type="checkbox"/> Continance</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Mental status (check all that apply, even if only from time to time)</p> <p>Recognize friends & family <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Sometimes</p> <p>Can describe own property <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Sometimes</p> <p>Can name all family members <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Sometimes</p> <p>Comments _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><i>Attorney use only</i></p> <p>Medicaid “medical necessity”? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p> <p>Capacity to sign POA’s? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p> <p>Capacity to sign will? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p> <p>Capacity to make gifts? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p>	<p><i>Attorney use only</i></p> <p>Medicaid “medical necessity”? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p> <p>Capacity to sign POA’s? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p> <p>Capacity to sign will? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p> <p>Capacity to make gifts? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/> Uncertain</p>

Your Medical Expenses

Please provide the MONTHLY cost of each	Spouse A per month	Spouse B per month
Nursing Home, Assisted Living Facility or home care cost if any		
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 (or Advantage plan) Company-Spouse A _____ Company-Spouse B _____		
<input type="checkbox"/> Other Medical Insurance Type _____ Company _____		
<input type="checkbox"/> Long Term Care Insurance		
Other Medical Expenses		

Your Military Service

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

Veteran's Name	Service 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*

Homestead Information Concerning Your Residence, If Owned By You

Location _____

Title is in the name of Spouse A Spouse B Both Other _____

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

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

Who lives there now? Spouse A Spouse B 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 Spouse A Spouse B Both Other _____

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

Mortgage Nothing (paid off) Presently owe \$ _____

Who lives there now? Spouse A Spouse B 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 Spouse A Spouse B Both Other _____

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

Mortgage Nothing (paid off) Presently owe \$ _____

Who lives there now? Spouse A Spouse B Both Tenant who pays no rent
 Tenant who pays rent of \$ _____ / month Tenant is family member? _____

TOTAL REAL PROPERTY \$ _____

Assets

Description	Title¹	Snapshot Date* Market Value	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					

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..

Description	Title ¹	Snapshot Date* Value	Most Recent Market Value	Debt secured by this asset	Beneficiary at Death
Certificated Shares, Bonds, Private Business interests, contract rights, notes receivable, etc.					
Other Assets, Rights, Expected Receipts/refunds					
Life Insurance Policies insurance company name; Death benefit amount	Insured Life & Policy Owner	Death Benefit	Cash Surrender value	Loan Amount	Beneficiaries
Safe Deposit Box & Contents	Contents	Value			
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>	

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

Attorney Notes re Closed Accounts

Trusts & Transfers

Spouse A	Spouse B
<p>Are you beneficiary of a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No Transferred assets to a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No Anticipate an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No Received an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, be sure anything you still own is listed among your other assets above.)</i></p>	<p>Are you beneficiary of a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No Transferred assets to a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No Anticipate an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No Received an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, be sure anything you still own is listed among your other assets above.)</i></p>
<p>Have you transferred cash or anything else, for less than fair market value, in last 5 years? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes Recipient _____ Asset description _____ Date _____ Value \$ _____ Received in return <input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> \$ _____ Cash <input type="checkbox"/> Other</p>	<p>Have you transferred cash or anything else, for less than fair market value, in last 5 years? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes Recipient _____ Asset description _____ Date _____ Value \$ _____ Received in return <input type="checkbox"/> Nothing (Gift) <input type="checkbox"/> \$ _____ Cash <input type="checkbox"/> Other</p>
<p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain purpose(s) of transfer _____</p>	<p>Was the transfer motivated, at least in part, by need for Medicaid eligibility? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain purpose(s) of transfer _____</p>

Attorney Notes re Transfers

Your Income

Please indicate monthly income

FIXED INCOME	Spouse A	Spouse B
Social Sec. Net Monthly Payment		
Medicare Part B premium		
Medicare Part D premium		
SSI		
VA		
Railroad Retirement		
Civil Service Annuity		
Other Retirement		
Pension		
Annuities		
Other Fixed Income		
<i>Attorney Use only</i>		
<i>Total fixed</i>		
VARIABLE INCOME	Spouse A	Spouse B
Gross Earned Income		
Interest		
Dividends		
Rent/Note		
Oil & Gas		
Farm Income		
Other		
<i>Attorney Use only</i>		
<i>Total variable</i>		
<i>Total income</i>		
POSSIBLE DEDUCTIONS		
Tax withheld from pension (monthly)		
Monthly health insurance premium(s)		

Questions concerning legal documents

Document	Spouse A	Spouse B
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<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	<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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Court Appointed Guardianship/ Estate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Court Appointed Guardianship/ Person	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Marital Property Agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Documents funding Trust (deeds, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain

<i>Attorney use only--</i> Notes concerning legal documents
<p><i>Attorney Use Only</i></p> <p>Goals of client(s)</p> <p><input type="checkbox"/> Acquire the best possible long term care, within their financial ability</p> <p><input type="checkbox"/> Avoid impoverishment of the spouse at home</p> <p><input type="checkbox"/> Avoid having to sell certain assets _____</p> <p><input type="checkbox"/> Acquire effective wills and powers of attorney</p> <p><input type="checkbox"/> Other _____</p> <p>_____</p> <p>_____</p>