

Farrell & Johnson PLLC

Long-Term Care & Estate Planning Questionnaire

Questionnaire completed by _____
 Relationship Husband Wife _____ of _____
 Conference is scheduled on _____ Who will attend? _____

Please do not try to convert this to Word. Open it in Adobe Acrobat and fill in the blanks, or print and complete in ink.

Husband	Wife
Full Name	Full Name
Date of Birth	Date of Birth
SSN:	SSN:
Home Address	Home Address <input type="checkbox"/> Same as Husband
County	County <input type="checkbox"/> Same as Husband
Mailing address if different	Mailing address if different
Phone -best	Phone -best
Other Phone-when/where?	Other Phone-when/where?
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)
Citizenship <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 this 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"/> Same as Husband <input type="checkbox"/> Date of this 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 _____

Husband's Nursing Home/Hospital History

Date In	Date Out	Name of Facility (& place if not Austin)	Nursing Home	Hosp	Rehab
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

“Snapshot date” for Husband if any (see below)* _____

Who provides significant assistance for Husband 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

Wife'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 Wife if any* _____

Who provides significant assistance for Wife now? (see below)* _____

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 Medicaid-certified nursing facility and stays at least 30 days, when the Medicaid program takes a “snapshot” of all assets of both Husband and Wife. Time on the 30 days continues to run if transferred to a hospital or another Medicaid-certified nursing facility.

Your Family

Do you (or either of 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

Do you have any grandchildren or great grandchildren under age 21? Yes No

Anyone in your family under age 21? Yes No **Anyone in your family have a disability?** Yes No

List below your children. If a child of yours has died, also list his or her children (your grandchildren) if any.

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?¹ 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

Attorney Notes re family and other sources of support, conflict or difficulty

**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.*

¹ "Disabled" for this purpose means receiving an income from Social Security because of a disability

Your Health

<p>Physical/Mental Condition of Husband</p> <p>Diagnoses _____ _____ _____</p> <p>Medication(s) _____</p> <p><input type="checkbox"/> Taking medication "as needed" (PRN)</p> <p>Personal care you are getting now _____ _____</p> <p><input type="checkbox"/> Using wheelchair <input type="checkbox"/> Using walker <input type="checkbox"/> Sometimes wanders <input type="checkbox"/> In locked unit or area</p>	<p>Physical/Mental Condition of Wife</p> <p>Diagnoses _____ _____ _____</p> <p>Medication(s) _____</p> <p><input type="checkbox"/> Taking medication "as needed" (PRN)</p> <p>Personal care you are getting now _____ _____</p> <p><input type="checkbox"/> Using wheelchair <input type="checkbox"/> Using walker <input type="checkbox"/> Sometimes wanders <input type="checkbox"/> In locked unit or area</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 <input type="checkbox"/> Walking <input type="checkbox"/> Eating <input type="checkbox"/> Medication <input type="checkbox"/> Continence</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 <input type="checkbox"/> Walking <input type="checkbox"/> Eating <input type="checkbox"/> Medication <input type="checkbox"/> Continence</p> <p>_____ _____ _____</p>
<p>Mental status (check all that apply, even if only from time to time when "at your best")</p> <p>Recognize friends & family <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes Can describe own property <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes Can name all family members <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes Can converse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes</p> <p>Comments _____ _____ _____ _____ _____</p>	<p>Mental status (check all that apply, even if only from time to time when "at your best")</p> <p>Recognize friends & family <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes Can describe own property <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes Can name all family members <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes Can converse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes</p> <p>Comments _____ _____ _____ _____ _____</p>
<p><i>Attorney use only</i></p> <p>Medicaid "medical necessity"? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain Capacity to sign POA's? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain Capacity to sign will? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain 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 Capacity to sign POA's? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain Capacity to sign will? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain 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	Husband <i>per month</i>	Wife <i>per month</i>
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-Husband _____		
Company-Wife _____		
<input type="checkbox"/> Other Medical Insurance		
Type _____		
Company _____		
<input type="checkbox"/> Long Term Care Insurance		
Maximum it will pay per month: \$ _____		
Maximum months it will pay: _____		
Other Medical Expenses		

Military Service

Have you, a spouse or deceased child(ren) ever been in the U. S. armed forces? YES NO

If so, is the veteran deceased, of service related cause(s)? YES NO

Does the veteran now have any service-related disability? YES NO

If so, is the disability 100%? YES NO If so, number of years it has been 100%: _____

Veteran's Name	Service Branch	Dates on Active Duty ²	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*

² Do not include Active Duty for Training. Do include active duty of a reservist or National Guard member when "called up" (activated).

Homestead Information Concerning Your Residence, If Owned By You

Already entered on page 1. If not, street address: _____
Title is in the name of Husband Wife Both Other _____
Bought during the marriage? YES NO
Property tax "fair market value" \$ _____
What you believe it would sell for if different: \$ _____
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
Acquired on or about _____
Title is in the name of Husband Wife Both Other _____
Property tax "fair market value" \$ _____
What you believe it would sell for if different: \$ _____
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
Acquired on or about _____
Title is in the name of Husband Wife Both Other _____
Property tax "fair market value" \$ _____
What you believe it would sell for if different: \$ _____
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 \$ _____

Other Assets

Description * See bottom of page 2 for definition of "Snapshot Date"	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: Show only value of items held only for investment value and not in personal use					
Bank & Credit Union accounts (checking, savings, CDs, money market funds, other cash equivalents)					
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	Title¹	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	Person Insured	Death Benefit	Cash Surrender Value	Loan Amount	Beneficiaries
Insurance Company name:					
Contents of Safe Deposit Box					
TOTAL ASSETS					

Your Debts

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.

Your Income

Please indicate monthly income

Monthly Income

FIXED MONTHLY INCOME	Husband	Wife
Social Security <i>Net</i> Monthly Payment		
Medicare Part B premium deducted		
Medicare Part D premium deducted		
Supplemental Security Income (SSI)		
VA Disability or Pension <i>Net</i> Monthly Payment		
Railroad Retirement <i>Net</i> Monthly Payment		
Civil Service Annuity <i>Net</i> Monthly Payment		
Required Minimum Distributions (average monthly)		
Pension <i>Net</i> Monthly Payment		
Annuities <i>Net</i> Monthly Payment		
Total of "Possible Deductions" below		
<i>Attorney Use only</i>		
<i>Total fixed</i>		
VARIABLE MONTHLY INCOME	Husband	Wife
Gross Earned Income		
Interest		
Dividends		
Rent/Note		
Oil & Gas		
Farm or Other Business Income		
Other		
<i>Attorney Use only</i>		
<i>Total variable</i>		
<i>Total income</i>		
POSSIBLE DEDUCTIONS		
Tax withheld from pension (monthly)		
Medical ins. premiums withheld from pension (monthly)		
Medical ins. premiums <i>not</i> withheld from pension (monthly)		
Total of Possible Deductions		

Trusts & Transfers

Husband	Wife
<p>Are you beneficiary of a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Transferred assets to a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anticipate an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Received an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If Yes, be sure anything you still own is listed among your other assets above.)</i></p> <p>Have you sold, traded or given away anything 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>Are you beneficiary of a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Transferred assets to a trust? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anticipate an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Received an inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>(If Yes, be sure anything you still own is listed among your other assets above.)</i></p> <p>Have you sold, traded or given away anything 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>

Attorney Notes re Trusts & Transfers

Questions concerning legal documents

Document	Husband	Wife
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
Medical Power of Attorney	<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 Guardian of the 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 Guardian of the 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
Revocable Living 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

Goals of client(s)

- Acquire the best possible long term care within their financial ability
- Avoid impoverishment of the spouse at home
- Avoid having to sell certain assets:
- Acquire effective wills and powers of attorney
- Protect a child or other person with a disability
- Other:

Checklist for Plan Preparation:

How to obtain documents to copy:

- Client provided all copies needed
- We copied all at first conference
- Return original documents with plan after copying
- Call _____ to pick up documents after copying
- Have documents hand delivered to _____ after copying

How to deliver plan:

- Call _____ to pick up at our office
- Have plan hand delivered to _____
- Have plan delivered by Fed Ex to _____
- Mail plan to the following: _____
- Email plan to the following: _____