

# HERITAGE ELDER LAW & ESTATE PLANNING, LLC

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## DETAILED PLANNING WORKSHEET

This information packet must be returned to us as soon as possible. (This will ensure we have enough time to understand the specifics of your situation before our meeting). If you need assistance completing the information, please call our office (724-841-0004).

Note: The information you provide in this questionnaire is a confidential communication between you and our firm, and it is gathered solely for the purposes of estate planning. This information will not be shared without your consent. If you decide not to retain Heritage Elder Law & Estate Planning, LLC, this information will be returned and/or destroyed upon request.

PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY. IF THE ANSWERS ARE UNKNOWN OR DOCUMENTATION IS UNAVAILABLE, PLEASE INDICATE AS SUCH.

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DETAILED PLANNING WORKSHEET

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

**This form is extremely important. Your accuracy and completeness in responding will help us to assess your situation.**

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**PERSONAL DATA**

**(Husband)** Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Social Security No. \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_ Email \_\_\_\_\_

U.S Citizen? Yes \_\_\_ No \_\_\_ Veteran? Yes \_\_\_ No \_\_\_ Date of Discharge \_\_\_\_\_

In skilled nursing care facility? Yes \_\_\_ No \_\_\_

If yes, Name and address of facility \_\_\_\_\_

❖ **Date entered facility:** \_\_\_\_\_

**(Wife)** Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Social Security No. \_\_\_\_\_

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

Telephone Number: \_\_\_\_\_ Email \_\_\_\_\_

U.S Citizen? Yes \_\_\_ No \_\_\_ Veteran? Yes \_\_\_ No \_\_\_ Date of Discharge \_\_\_\_\_

In skilled nursing care facility? Yes \_\_\_ No \_\_\_

If yes, Name and address of facility \_\_\_\_\_

❖ **Date entered facility:** \_\_\_\_\_

Can we send appointment confirmation texts?  Yes  No Cell phone # \_\_\_\_\_

Name of person receiving text message \_\_\_\_\_

**AGENT UNDER POWER OF ATTORNEY**

**Name** \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

**CHILDREN** (if applicable, including adult children)

**Name of Child** \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**Name of Child** \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**Name of Child** \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**Name of Child** \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**I have no Children**

**Additional Children?** If yes, provide contact information on reverse.

Yes  No

Does the Husband have any children by a previous marriage?

Yes  No

Does the Wife have any children by a previous marriage?

Yes  No

Are all of your children in good health?

Yes  No

Are any of your children receiving SSI or other form of government entitlement?

Yes  No

Are any of your children blind or disabled?

Yes  No

Is anyone in your immediate or extended family disabled?

Yes  No

Do any of your family members have any problems with:

Aids

Yes  No

Drug Addiction?

Yes  No

Alcoholism?

Yes  No

Spendthrift?

Yes  No

Do any of your children live with you in your home?

Yes  No

If yes, name of child \_\_\_\_\_

Does a sibling live in your home with you?

Yes  No

If yes, name of sibling \_\_\_\_\_

**MONTHLY INCOME\***

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (Include Medicare Part B Deduction, if applicable)	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
Veterans Disability Income	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
<b>TOTAL MONTHLY INCOME</b>	<b>\$ _____</b>	<b>\$ _____</b>

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future?

Yes  No

*\*Do not include interest and dividend income on this form*

**MONTHLY COST OF NURSING HOME / ASSISTED LIVING FACILITY**

**Currently Living in:**  Nursing Home  Assisted Living  Home (or with family member)

**Care is being paid:**  Out of Pocket  Medicare  Medicaid

Monthly Nursing Home/ALF Cost \$ \_\_\_\_\_

Monthly Prescription Cost \$ \_\_\_\_\_

Monthly Incontinent Cost \$ \_\_\_\_\_

Monthly Other Cost \$ \_\_\_\_\_

**Total Monthly Cost** \$ \_\_\_\_\_

The nursing home/ALF is paid through \_\_\_\_\_ (month/year).

**MONTHLY SHELTER EXPENSES**

(Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage \$ \_\_\_\_\_

Real Estate Taxes \$ \_\_\_\_\_

Homeowner's insurance premium \$ \_\_\_\_\_

Condominium /Homeowner Association fees \$ \_\_\_\_\_

Utilities \$ \_\_\_\_\_

**Total Monthly Housing Expenses** \$ \_\_\_\_\_

**MONTHLY NON-SHELTER LIVING EXPENSES**

Please list any significant monthly non-shelter living expenses not disclosed above:

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**GIFTS**

Have you made gifts in excess of \$500 in any one month including but not limited to: **college tuition payments, monetary gifts to the church, or Christmas/Birthday gifts** to an individual or group of individuals, or transfer any funds to an individual or group of individuals, within the past 60 months, or to a trust within the past 60 months or were names removed from any bank, investment or financial accounts held jointly with another individual?  Yes  No

If Yes:

Gifting date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Amount: \$ \_\_\_\_\_ Recipient: \_\_\_\_\_

Gifting date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Amount: \$ \_\_\_\_\_ Recipient: \_\_\_\_\_

Gifting date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Amount: \$ \_\_\_\_\_ Recipient: \_\_\_\_\_

*\*If there were more than three gifts, please use an additional sheet of paper*

Have you ever filed a Federal Gift Tax Return?  Yes  No

If so, for what calendar year(s)? \_\_\_\_\_

**LIFE INSURANCE/LONG TERM CARE INSURANCE**

**Insurance Company** \_\_\_\_\_ **Policy #** \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_

**Insurance Company** \_\_\_\_\_ **Policy #** \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_

**Insurance Company** \_\_\_\_\_ **Policy #** \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value \$ \_\_\_\_\_ Cash Value \$ \_\_\_\_\_

**ASSETS/LIABILITIES**

**Please insert the value of each asset in the appropriate space.**

ASSETS	HUSBAND	WIFE	JOINT	DEBTS	COMPANY/ ACCOUNT #
Personal Effects/Household Items					
Automobile					
Additional Automobiles					
Checking Account					
Savings Account					
Money Market Account					
Certificates of Deposit					
Residence (Assessed Value) (Obtain from Tax Bill)					
Other Real Estate					
Mutual Funds					
Stocks					
Bonds					
Annuities					
Retirement Accounts					
Cash on Hand					
Gold/Silver					

What did you pay for your current home including any improvements? \$ \_\_\_\_\_

Address of any real property **other** than personal residence:

(1) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_  
 Tax Block # \_\_\_\_\_, Lot # \_\_\_\_\_ (Can be obtained from Tax Bill)

Have you sold or transferred any property in the past 60 months?  Yes  No

Have you sold, traded in, or transferred any vehicles in the past 60 months?  Yes  No

What is the current mileage on your vehicles? 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**YOUR ADVISORS:**

**Name**

**Telephone No.**

Accountant

\_\_\_\_\_

\_\_\_\_\_

Life Insurance Agent

\_\_\_\_\_

\_\_\_\_\_

Investment Advisor

\_\_\_\_\_

\_\_\_\_\_

Other Attorney

\_\_\_\_\_

\_\_\_\_\_

Other Consultant or Advisor

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL DATA**

**1. HEALTH**

Name of Ill Spouse \_\_\_\_\_

Diagnosis \_\_\_\_\_

Prognosis \_\_\_\_\_ Course of Treatment \_\_\_\_\_

Name of Well Spouse \_\_\_\_\_

Where Well Spouse Currently Resides \_\_\_\_\_

Health of Well Spouse \_\_\_\_\_

**2. PHYSICIAN**

Full Name of Husband's Primary Physician \_\_\_\_\_

Street Address \_\_\_\_\_

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

Full Name of Wife's Primary Physician \_\_\_\_\_

Street Address \_\_\_\_\_

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



**MISCELLANEOUS**

- Do you have an irrevocable burial account?  Yes  No
- Do you have a current Will?  Yes  No
- Do you have a Living Will?  Yes  No
- Do you have a Power of Attorney?  Yes  No
- Have you ever applied for or received government benefits before?  Yes  No
- Are you currently on PACE or any other state pharmaceutical plan?  Yes  No
- Do you have a Medigap (supplemental health insurance) policy?  Yes  No
- Do you have any other legal issues that we should be aware of:  Yes  No

If yes, please explain:

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**REFERRAL**

By whom were you referred to this office?

Name

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**CERTIFICATION**

The undersigned hereby represents to Heritage Elder Law & Estate Planning, that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

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# HERITAGE ELDER LAW & ESTATE PLANNING

## Long-Term Care Documentation List

If you are able, please bring the following documentation to your initial consultation for Long-Term Care Planning. **You MUST bring a copy of the Power of Attorney.**

- Copy of Power of Attorney or guardianship papers.
- Social Security card for self and spouse (if living).
- Birth verification - copy of birth certificate for self and spouse (if living).
- Copy of driver's license or other Photo identification.
- Naturalization/alien registration if foreign born.
- Marriage license or certificate and/or death certificate of spouse.
- Military discharge papers for client and/or spouse, if applicable.
- Previous marriage certificates for either partner and divorce / Annulment / Separation papers (if applicable).
- Medicare card for self and spouse (if living).
- Supplemental Health Insurance Cards.
- Health Insurance premium notice for self and spouse.
- Nursing Home Bill and Nursing Home Contract (Admissions agreement, responsible party agreement and/or Personal care contract)
- Documentation of all financial accounts held individually and/or jointly. Copies of checking account statements with corresponding checkbook register, savings account, CDS, stocks, bonds, money markets, trusts, annuities, IRA/Retirement accounts etc. for the **previous five years.**
  - o **Copies of any checks more than \$500 on these statements.**
- Deed(s), current property tax card(s), and mortgage statement.
- Sales agreements of property if sold within the last 5 years. (HUD-1)
- Funeral contracts and/or cemetery lot deed(s)
- Life insurance policies (spouse's if living). Please provide documentation of the face and current cash value of each policy.
- Titles or lease agreement to all vehicles and current mileage.
- Sales agreement for any vehicles sold in the last 5 years.
- Proof of all monthly income (spouse's if living). Please provide copies of award letters [Social Security, VA Benefits] or let us know if it's only shown on bank statements.
- Proof of any income you have applied for (VA, SSI, SSD).
- If spouse is living, we need proof of living expenses, including rent or mortgage payment, utilities and homeowner's or renter's insurance.
- Copies of any applications previously submitted to Department of Public Welfare
- Award letters or other correspondence from Department of Public Welfare
- Income Tax returns, including 1099 year end statements for last 5 years

**ALL DOCUMENTATION LISTED IS REQUIRED FOR A MEDICAID APPLICATION. ADDITIONAL DOCUMENTATION MAY BE REQUESTED BASED ON YOUR UNIQUE CASE.**