HERITAGE ELDER LAW
&
ESTATE PLANNING, LLC

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.

DETAILED PLANNING WORKSHEET

Today's Date _____

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

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	$_____	$_____
TOTAL MONTHLY INCOME	**$_____**	**$_____**

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:

_____

_____

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:

_____

_____

REFERRAL

By whom were you referred to this office?

Name

_____

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 in inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

_____

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 2 years and January/July Statements for 3 years prior**.
    - Example: If you meet with us on September 1, 2000, we need January and July 1996, January and July 1997, January and July 1998, and September 1, 1998 - September 1, 2000
    - 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 year

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