



Timothy K. Palmer, P.C.

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LONG-TERM CARE PLANNING QUESTIONNAIRE (MARRIED)

Date, Home Phone No., Husband's Work Phone No., Husband's Cell No., E-mail Address, Contact Person, Wife's Work Phone No., Wife's Cell No., Fax No.

This form is extremely important. Your accuracy and completeness in responding will help Timothy K. Palmer, P.C. represent you. Bring this information with you to the appointment. Please PRINT and use full legal names so they are legible. This information may be used to prepare Estate Planning Documents.

A. PERSONAL DATA

(Husband) Full Name, Street Address, City, State, Zip, Birth Date, Social Security No., U.S. Citizen?, Marriage Date, Annual Income. (Wife) Full Name, Street Address, City, State, Zip, Birth Date, Social Security No., U.S. Citizen?, Annual Income.

B. REFERRAL

By whom were you referred to this office? Name, Street Address, City, State, Zip

Have you heard our radio ad? Have you seen our newspaper ad? Have you visited our Website? Yes/No options.

Do you have any ideas for improving our Website? If so, please discuss.

C. CHILDREN (please print full legal names so they are legible)

Child's Name	Address (including zip code)	Phone Number	Date of Birth

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 blind? ___ Yes ___ No

Are any of your children disabled? ___ Yes ___ No

Have all of your children completed their education? ___ Yes ___ No

Are any of your children receiving SSI or other form of government entitlement? ___ 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
Marital Problems?	___ Yes	___ No

D. GRANDCHILDREN (please print full legal names so they are legible)

Grandchild's Name	Address (including zip code)	Date of Birth

E. DISPOSITIVE INTENTIONS

1. SPOUSE AND CHILDREN

Do you wish to provide primarily for your spouse and secondarily for your children? ___ Yes ___ No

Do you wish to treat all of your children equally? ___ Yes ___ No

If not, why not? _____

After your spouse's death, at what age do you want distribution to your children? _____
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

2. GRANDCHILDREN

Do you want to leave a specific amount of money or a percentage of your estate to your grandchildren? ___ Yes ___ No

Do you wish to treat all of your grandchildren equally? ___ Yes ___ No

If not, why not? _____

How much do you want to leave your grandchildren? _____

At what age do you want distribution to your grandchildren? _____
(e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

3. CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? ___ Yes ___ No

If yes, please list:

Name of Charity	Address of Charity	Dollar Amount

4. OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than children, grandchildren or a charity? ___ Yes ___ No

If so, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount

F. MEDICAL INFORMATION

1. HEALTH

Name of Ill Spouse _____

Diagnosis _____

Prognosis _____

Residing _____

Is this a nursing home? ___ Yes ___ No

If yes, date entered _____

Name of Well Spouse _____

Health of Well Spouse _____

Where Well Spouse Currently Resides _____

Is this a nursing home? ___ Yes ___ No

If yes, date entered _____

2. PHYSICIAN

Name of Primary Physician _____

Address _____

City _____ State _____ Zip _____

3. HEALTH INSURANCE INFORMATION

Husband's Primary Insurance

Name of Carrier _____

Subscriber/Policy Number _____

Wife's Primary Insurance

Name of Carrier _____

Subscriber/Policy Number _____

Do you want to donate your eyes or organs? ___ Yes ___ No

G. MONTHLY INCOME

	<u>Husband</u>	<u>Wife</u>
Social Security Benefits	\$ _____	\$ _____
Medicare Part B Deduction	\$ _____	\$ _____
Other Health Insurance Premiums	\$ _____	\$ _____
Retirement Benefits (gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____	\$ _____

H. MONTHLY SHELTER EXPENSES

Monthly Nursing Home Cost \$ _____

Monthly Prescription Cost \$ _____

Monthly Other Cost \$ _____

TOTAL MONTHLY COST \$ _____

I. MONTHLY SHELTER EXPENSES

Rent/Mortgage \$ _____

Real Estate Taxes \$ _____

Water \$ _____

Sewer \$ _____

Utilities (Gas, Electricity, Phone) \$ _____

Homeowner's Insurance premium \$ _____

Condominium Fees \$ _____

Other Expenses \$ _____

Total Monthly Housing Expenses \$ _____

J. MONTHLY NON-SHELTER LIVING EXPENSES

Food \$ _____
Medical \$ _____
Clothing \$ _____
Transportation
(including auto insurance) \$ _____
Home Maintenance \$ _____
Life Insurance Premiums \$ _____
Cable TV \$ _____
Federal & State Income Taxes \$ _____
Other \$ _____

**Total Monthly Non-Shelter
Living Expenses** \$ _____

K. GIFTS

Have you ever made gifts in excess of \$3,000 in any one month to an individual or group of individuals within the last 36 months? If so, please list below:

Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____

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

**LONG-TERM CARE PLANNING-ASSET INFORMATION
(MARRIED)**

L. FINANCIAL SUMMARY

		ASSETS			LIABILITIES
	HUSBAND	WIFE	JOINT		
BANK ACCOUNTS					
CHECKING					
SAVINGS					
MONEY MARKET					
PERSONAL EFFECTS					
AUTOMOBILE					
RESIDENCE					
OTHER REAL ESTATE					
CERTIFICATE OF DEPOSIT					
STOCKS					
BONDS					

MUTUAL FUNDS				
BUSINESS INTEREST				
JEWELRY & COLLECTIBLES				
NON-IRA TAX QUALIFIED RETIREMENT				
IRA'S				
ANNUITIES				
LIFE INSURANCE				
PRE-PAID FUNERAL				
OTHER ASSETS				
TOTAL ASSETS				

PLEASE PROVIDE DOCUMENTATION FOR EACH ASSET LISTED ABOVE

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

M. PROPERTY INFORMATION

Personal Residence:

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

Addresses of real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

(2) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

N. LIFE INSURANCE*

Company	Policy #	Type	Death Benefit	Face Value	Cash Value	Insured	Owner	Beneficiary

***Please attach additional pages if necessary**

O. CERTIFICATION

The undersigned hereby represents to Timothy K. Palmer, P.C., and each of its staff 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.

Date

Signature of Client or Client Representative