WEALTH PLANNING LAW GROUP

ATTORNEYS AT LAW

Protecting Your Legacy

Confidential

Long-Term Care Planning

Questionnaire

Phone: (504) 982-8207

101 Allen Toussaint Blvd, Suite 404, New Orleans, LA 70124-2560

WEALTH PLANNING LAW GROUP
ATTORNEYS AT LAW
Protecting Your Legacy

LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

Date of Appointment: _____ Referred by: _____

Client's First, Middle/Maiden and Last Name (List both Spouses' names if applicable)

Husband's Company/Position: _____

Husband's DOB: _____ Social Security #: _____

Office	Cell	Email	Home

Full Name of Husband's Prior Spouse(s)	Result
	☐ Divorce ☐ Deceased While Married ☐ Currently Married
	☐ Divorce ☐ Deceased While Married ☐ Currently Married
	☐ Divorce ☐ Deceased While Married ☐ Currently Married

Wife's Company / Position: _____

Wife's DOB: _____ Social Security #: _____

Office	Cell	Email	Home

Full Name of Wife's Prior Spouse(s)	Result
	☐ Divorce ☐ Deceased While Married ☐ Currently Married
	☐ Divorce ☐ Deceased While Married ☐ Currently Married
	☐ Divorce ☐ Deceased While Married ☐ Currently Married

Home Address: _____

Billing Address (if different): _____

Indicate Primary Contact Method: ☐Home ☐ Office ☐ Cell ☐ E-mail

How did you hear about us? _____ Are Both Spouses U.S. Citizens? ☐Yes ☐No

FAMILY INFORMATION

Child's Name	Nickname	DOB	Married	# of Children	Biological Parents	Concerns
			☐Yes ☐No			☐Yes ☐No
			☐Yes ☐No			☐Yes ☐No
			☐Yes ☐No			☐Yes ☐No
			☐Yes ☐No			☐Yes ☐No
			☐Yes ☐No			☐Yes ☐No
			☐Yes ☐No			☐Yes ☐No
			☐Yes ☐No			☐Yes ☐No
			☐Yes ☐No			☐Yes ☐No

Any Special Circumstances with the children? (e.g., Predeceased, adopted, special needs, disinherit);

Explain: _____

_____

Do you have disability insurance? ☐Yes ☐No

Do you have long term care insurance? ☐Yes ☐No

Are you or your spouse a wartime veteran? ☐Yes ☐No

Did you serve during any of the following? ☐Yes ☐No Years of Service From: ___/___/_____ to ___/___/_____

World War II – December 7, 1941 through December 31, 1946

Korean Conflict – June 27, 1950 through January 31, 1955

Vietnam Era – February 28, 1961 through August 5, 1964 for those who served in the Republic of Vietnam (All others August 5, 1964 through May 7, 1975)

Persian Gulf War – August 2, 1990 through a date to be prescribed by Presidential proclamation or law.

Please describe in percentage terms who would receive your assets under your current plan and who would receive your assets ideally.

	Current %	Ideal %
Children	%	%
Grandchildren		
Other Loved Ones		
Charity		
IRS		

ASSET INFORMATION

Do you have any Separate Assets, Prenuptial or Separate Property Agreements? ☐Yes ☐No

Have you/your spouse ever made gifts exceeding $10,000? ☐Yes ☐No

Was a gift tax return filed? ☐Yes ☐No

If "Yes" to any of the above, please provide copies and explain: _____

_____

If you prefer, please attach a Personal Financial Statement rather than completing the remaining asset information

PERSONAL RESIDENCE

Home (Street Address)	Gross Value	Mortgage	Fair Market Value (FMV)

REAL ESTATE HELD INDIVIDUALLY

*List TYPE: Commercial (**C**), Rental (**R**), Condo (**CN**), Timeshare (**TS**), Vacant (**V**)*

Municipal Address	Type	Gross Value	Mortgage	Net FMV

RETIREMENT PLANS, IRA's & ANNUITIES

For each, list TYPE OF PLAN (e.g., IRA, 401(k) or Annuity), BROKER DEALER (e.g., LPL, NY Life, Bank, etc.), Financial Advisor, Owner /Beneficiary (e.g., Husband (H) / Wife (W)) & FMV

Type of Plan	Broker Dealer	Financial Advisor	Owner	Beneficiary	FMV

AFTER TAX, MUTUAL FUND OR STOCK INVESTMENTS

Broker Dealer Where Account is Held	Investment Advisor's Name	FMV

LIFE INSURANCE

List INSURED/OWNER/BENEFICIARY of each policy (e.g., Husband (H)/ Wife (W)/ Trust (T)/ Children (C)), Ins. Company, Policy TYPE (e.g., Term/Whole Life, Universal Life) & Agent, CASH VALUE and Death Benefit:

Insured	Owner	Beneficiary	Company/Policy Type/Agent	Cash Value	Death Benefit

BUSINESS INTERESTS

For each company, list NAME, TYPE (e.g. L.L.C., Partnership (P/S), C – Corporation (C-Corp) or S – Corporation (S-Corp), OWNERSHIP %, how much you could sell it for and whether you have a Buy-Sell agreement:

Full Name of Company	Type	Ownership %	Approx. Value of your %	Buy-Sell?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCE:.

Briefly describe or give the name of the Trust in which the individual(s) needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

_____

_____

_____

PERSONAL PROPERTY, BANK ACCOUNTS AND OTHER ASSETS NOT LISTED ABOVE

_____

_____

Miscellaneous:

If either or both persons needing long-term care have any property interests not listed above, please describe and list the value of such assets:

_____

_____

_____

NET WORTH: _____ **ANNUAL HOUSEHOLD INCOME:**_____

CONCERNS AND OBJECTIVES

Our goal is to individually tailor solutions that address your individual estate planning objectives. Please review the following items to identify the issues that most concern you.

Level of Concern (1-10) | 1 = Lowest and 10 = Highest

Tax Concerns

Risk of the IRS "inheriting" 40% of your estate when you die ----------
Risk of capital gains taxes being paid on the sale of assets ----------
Risk of unnecessary income tax being paid on investment assets ----------

Family Concerns

Risk that assets left to your spouse might not pass to your intended heirs if your spouse remarries ----------
Risk of a child or other beneficiary losing his or her inheritance to creditors, lawsuits, or to a divorcing spouse ----------
Risk of a child or other beneficiary losing his or her inheritance due to the mismanagement of your assets ----------
Risk that an inheritance received by a child with a disability would disqualify them for governmental benefits ----------
Risk of unnecessary litigation from heirs who receive less than they think they are entitled to receive ----------

Disability Concerns

Risk of loss of control over your assets currently or in the event of your disability ----------
Risk of legal conservatorship in event of your disability ----------
Risk of unwanted efforts made to save your life instead of dying peacefully and without pain ----------
Risk that your doctor won't release health care information for lack of HIPAA releases ----------

Creditor Concerns

Risk of lawsuits against you ----------
Risk of loss of your assets to a nursing home ----------

Post Death Concerns

Risk of having to sell assets in a "fire sale" in order to create the liquidity needed to pay taxes and expenses ----------
Risk that your executor will innocently make mistakes because they don't know the responsibilities and liabilities of serving ----------
Risk of private matters unnecessarily being made public ----------
Risk that property you intend to preserve in the family will have to be sold upon your death ----------

Business Concerns

Risk that corporate shield will fail to protect corporate assets because corporate meetings have not been held annually, corporate minutes kept, officers elected, etc. ----------
Risk of business failure due to the lack of business succession plan ----------
Risk of unnecessary expenses associated with the sale of a business because of the absence of an exit plan having been prepared ahead of time ----------
Risk of unintended financial results from a Buy/Sell Agreement that is out of date and/or underfunded ----------
Risk that your business will fail on your disability or death
Risk that the business will not sell for full value after your disability or death ----------

HEALTH & CAPACITY ISSUES

I. HEALTH RELATED PROBLEMS

Health Problems: Client

Health Problems: Spouse/Significant Other

II. CAPACITY

Are there any known problems with the individual's memory or understanding?

Client: Yes ◯ No ◯
Spouse/Significant Other: Yes ◯ No ◯

If you answered **yes**, please describe the nature of the problem:

Please indicate Yes or No to the following questions:

	Client	Spouse/ Significant Other
Is the individual able to sign his or her name?		
Able to speak?		
Able to recognize family members and acquaintances?		
Cognizant of his or her property and personal possessions?		
Able to travel outside his or her current place of residence?		

III. PHYSICIAN'S INFORMATION

	Client	Spouse/Significant Other
Physician's Name:		
Specialty:		
Address:		
Business Telephone:		

IV. RESIDENCE – OWNED

A. Owner(s): Husband & Wife / Other:_____

B. How is the title held? _____

PLEASE PROVIDE US WITH A COPY OF THE DEED AND MOST RECENT TAX BILL.

C. Fair Market Value? $_____

D. Outstanding Mortgage: $_____

If so, is it a Reverse Annuity Mortgage (RAM)? Y / N

Basic terms: _____

E. Single family residence? Y / N

F. If the property is a double or multiplex, please provide the following:

1. Number of units: _____
2. Currently being rented? Y / N Monthly Rent: _____
3. Are tenants under lease? Y / N

G. If the property was <u>purchased</u>, please provide the following:

1. Date of purchase: _____
2. Purchase price: $_____

H. If the property was <u>inherited</u>, please provide the following:

1. Month/year of inheritance _____
2. Approximate value on date of inheritance: $_____

I. If improvements have been made to the property, please detail the value and nature of the improvements:

_____

_____

J. Has (have) the owner(s) used the principal residence capital gains tax exclusion? Y / N

K. If at least one occupant of the residence is a <u>child</u> of the individual needing long-term care, has that child lived in the residence for at least two (2) years? Y / N

1. Has the child provided personal care to the parent(s) that might have delayed the need for long-term care for the parent(s)? Y / N

2. If yes, please describe the nature and duration of the care provided:

L. Do the individual(s) needing care have any living children who are disabled? Y / N

If yes, please describe the nature of the disability:

M. If the owner has a <u>brother or sister</u>, has the brother or sister lived in the house for at least one (1) year? Y / N

If yes, does the sibling still reside in the home? Y / N

V. RESIDENCE – RENTED (Fill this out only if you rent your residence rather than own it)

Monthly Cost: $_____

Type of rental:

Single Family	☐	Apartment	☐
Residential Care	☐	Life Care	☐
Senior Housing	☐		

Is there a rental or lease agreement? Y / N

Is the rent being subsidized? Y / N

If so, by whom and for how much? $_____

VI. LONG-TERM CARE (LTC)

	Client	Spouse/Significant Other
Is the individual(s) currently receiving long-term care?	Y / N	Y / N
If so, what was the date of entry into the nursing home or facility, or the date the home care was started?	_____	_____

Name of the LTC facility/provider: _____

Address: _____

_____

Business Telephone: _____

Administrator or other contact: _____

VII. HOSPITAL/ LONG TERM CARE FACILITY

	Client	Spouse/Significant Other
Is either individual currently in a hospital?	Y / N	Y / N

Name/Location of the Hospital: _____

Date admitted: _____

Please list the current duration of the hospital stay, and a brief description of the medical problem:

	Client	Spouse/Significant Other
Is placement in a LTC facility expected?	Y / N	Y / N
If placement is expected, is it likely that he or she will return home?	Y / N	Y / N

VII. INCOME

In completing the following section, use the "name on the check" rule, i.e., the individual(s) whose name appears on the payment vehicle is the "owner" of the income.

Fixed Monthly	Client	Spouse/Significant Other	Joint
Social Security	$	$	$
R.R. Retirement	$	$	$

Pension	$	$	$
Other (describe)			
	$	$	$
	$	$	$
Non-Fixed Monthly			
Interest	$	$	$
Dividends	$	$	$
Other (describe)			
	$	$	$
	$	$	$
TOTAL INCOME	$	$	$

IX. EXEMPT RESOURCES

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the individual needing care has the listed items: (please indicate yes or no)

	Client	Spouse/Significant Other
Burial plot: (Please provide a copy of deed)	Y / N	Y / N
Irrevocable burial fund contract: (Please provide a copy)	Y / N	Y / N

X. RESPONSIBLE PERSONS

Who now has "assistance" responsibilities (i.e., are any family member or other individuals providing custodial or other types of care to the individual needing assistance)? Please list name, phone number, and relationship to the person receiving the care:

For Client:	
For Spouse/Significant Other:	

XI. UNAVAILABLE CHILD(REN)

If the individual needing care has children, and any child(ren) are not to be relied upon for any reason to help with management or other needs of parent(s), please list name of such child(ren) and provide a short explanation why you believe such is the case:

_____

_____

_____

XIV. COST OF LIVING (ESTIMATED PER MONTH)

Housing	Client	Spouse/Partner	Joint
If home is owned, estimate total cost of mortgage, taxes, utilities, phone, etc.* (Monthly)	$	$	$
If rented, estimate monthly rental/lease expense (including any maintenance fees)	$	$	$
Insurance Premiums (Monthly)			
Health	$	$	$
Long-term care	$	$	$
Other (specify):	$	$	$
Medical Expenses			
Non-covered medications (monthly est.)	$	$	$
Other (specify): _____	$	$	$
_____	$	$	$
Basic Living Expenses			
Food	$	$	$
Entertainment & Travel	$	$	$
Support for child(ren)	$	$	$
Other (specify):	$	$	$

TOTALS	$	$	$

Is the veteran's real property tax exemption being used? Y / N

XIII. HEALTH AND LTC INSURANCE

Use back of form if necessary (Please provide us with a copy of each document)

If either and/or both individual(s) have Medicare Parts A, B and/or D, private health or long-term care insurance, or are paying for a Medicare supplement policy, please provide the following information:

Name of Insurer and Policy #	Type of Policy	Monthly Premium	If LTC Insurance Daily Benefit

XIV. TRANSFERS WITHIN 60 MONTHS

Has the individual(s) transferred property to someone other than his or her spouse within the past sixty (60) months? If so, please provide the following information:

Client:

Recipient	Asset	Value	Date
		$	
		$	

Gift tax returns filed on any gifts? (Please provide copies, if available) Y / N

Spouse/Significant Other:

Recipient	Asset	Amount	Date
		$	
		$	

Gift tax returns filed on any gifts? (Please provide copies, if available) Y / N

XV. TRANSFERS TO OR FROM TRUSTS

Has the individual(s) transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past sixty (60) months?

Client: Y / N Spouse/Significant Other: Y / N

If so, please provide the following information:

Name of Trust	Asset	Amount	Date
		$	
		$	

Please complete the portions of following paragraphs that provide for the names of personal representatives and alternates below.

XVI. Veterans Benefits

A. Were you or your spouse a Veteran? Y / N
If Yes, please write name(s) of Veteran(s) here: _____.
(If no, please proceed to next section)

B. Dates of Service _____to_____.

C. Was the Veteran Honorably Discharged? Y / N
   a. If No, please provide details of Discharge:

_____

_____

_____

_____

D. If you have any dependents, please provide their names:

_____

_____

E. Is the Veteran either 65 years of age or older or any age with permanent and total disability?

Y / N

F. Does the Veteran have problems with dressing, bathing, incontinence, bedridden, or with hazards incidental to daily environment such that the Veteran would have a disability rating of 60% or higher? (Please circle all that apply) Y / N

Pension Benefit 2014 Figures – Wartime Vet

Wartime Veteran		
Type of Benefit	**Max Pension Rate**	
Service Pension	$1,054 / mo.	$12,652 / yr.
One Dependent	$1,381 / mo.	$16,569 / yr.
Housebound	$1,288 / mo.	$15,462 / yr.
One Dependent	$1,615 / mo.	$19,380 / yr.
Aid & Attendance	$1,758 / mo.	$21,107 / yr.
One Dependent	$2,085 / mo.	$25,022 / yr.
Vet Married to Vet	$2,790 / mo.	$33,480 / yr.
Each Add'l Dependent	$180 / mo.	$2,161 / yr.

2014 Pension Benefit – Surviving Spouse

Surviving Spouse		
Type of Benefit	**Max Pension Rate**	
Death Pension	$707 / mo.	$8,485 / yr.
One Dependent	$926 / mo.	$11,107 / yr.
Housebound	$864 / mo.	$10,371 / yr.
One Dependent	$1,082 / mo.	$12,988 / yr.
Aid & Attendance	$1,130 / mo.	$13,563 / yr.
One Dependent	$1,348 / mo.	$16,180 / yr.
Each Add'l Dependent	$180 / mo.	$2,161 / yr.

XVII. LAST WILL AND TESTAMENT:

A. PERSONAL PROPERTY

(1) Any specific Bequests you would like to make to Family/ Friends? Please Describe:

_____

_____

(2) Would you prefer to provide a handwritten, dated, and signed listing of bequests? Y / N

B. RESIDUARY / REMAINING ESTATE ASSETS

(1)☐ To children with spousal lifetime / legal usufruct
(2)☐ In trust for asset protection
(3)☐ Other: _____

C. ADDITIONAL CONSIDERATIONS FOR YOUR INITIAL CONSULTATION

1. Is there anyone outside your immediate family whom you wish to leave assets to, such as: charities, friends, grandchildren, etc.?

_____

2. If you passed away today, who would you want to handle your affairs as Executor:

Executor	First Choice	Second Choice

3. If you passed away today, are your children capable of immediately managing their inheritance? If not, please list blow those people you would like to name as trustees of your testamentary trust to manage your wealth in the event of your death (include your Spouse if appropriate). Also, please identify an institutional trustee to serve as a final successor trustee. This could include any of the major banks or a trust department from the financial institution that your financial advisor works with.

Trustees	First Choice	Second Choice	Third Choice	Final Institutional Trustee

4. If you were incapacitated indefinitely, who would make health care decisions for you and manage your financial affairs? Please list your "spouse" as first choice, if appropriate.

Health Care and Power of Attorney Agent		Husband's Response	Wife's Response
	First Choice		
	Second Choice		

Please list the advisors that you work with:

Life Insurance Agent	Financial Advisor	CPA	Other Advisors

Additional Documentation

Please bring to your initial appointment the following documents

Copy of any existing planning documents including: wills, trusts, business entities, buy/sell agreements, separate property agreements, and any reservations of separate property that you have made.

XVIII. DISPOSITION OF REMAINS APPOINTMENT: (Designated to handle one's remains and final arrangements once deceased.)

	Name:	Address:	Phone:
(1)	_____,	_____	_____
		_____	
(2)	_____,	_____	_____
		_____	
(3)	_____,	_____	_____
		_____	

Funeral Instructions: (If any – Check Applicable)

☐ Cremation ☐ Memorial Service ☐ Calling Hours ☐ Open casket ☐ Closed casket

☐ Service at Funeral Home ☐ Service/Mass in Church ☐ With casket ☐ Interment service at Cemetery

☐ Other: _____

Funeral Home:_____ Pre-Planned: ☐ Yes ☐ No

Cemetery Plot: _____

CHECKLIST OF ITEMS TO BRING TO YOUR APPOINTMENT

Check if you have any of the following instruments, and provide copies if available.

Client	Spouse/Significant Other	
☐	☐	Prior Will
☐	☐	Trust documents where you are listed as donor or beneficiary
☐	☐	Power of Attorney, Living Will, and/or Health Care Proxy
☐	☐	Business Agreements (Partnership/Shareholder)
☐	☐	Pre-Nuptial Agreement
☐	☐	Waiver of Right of Election
☐	☐	Deeds to Real Property
☐	☐	Recent Tax Bill Associated with Deeds
☐	☐	Recent Real Property Appraisals
☐	☐	Qualified Plan/IRA/ 401(k) Statements
☐	☐	Bank Account / CD Statements
☐	☐	Investment Statements (Stocks, Bonds, Mutual Funds)
☐	☐	Funeral Pre-Planning / Cemetery Plot Information
☐	☐	Life Insurance Policies
☐	☐	Long-Term Care Insurance Policy
☐	☐	Any Current Beneficiary Elections
☐	☐	Prior Gift Tax Returns
☐	☐	Last 2 years Federal Income Tax Returns

Wealth Planning Law Group

101 Allen Toussaint Blvd., Suite 404 | New Orleans, LA 70124

Phone: (504) 982-8207 Email: Todd@LAWEALTHPLAN.com

www.LaWealthPlan.com