Long Term Care Initial Intake Questionnaire

The information contained in the following questionnaire is essential for us to know so that we may properly plan for you. Please complete the form to the best of your ability. All of the information which you provide will remain a part of your client file and is confidential. Please note the term "client" generally refers to the ill or incapacitated individual.

Today's Date:_____

Name of Individual completing this form:_____

Relationship to Client (if not completed by Client):_____

Names of other persons attending this meeting:_____

Who referred you to my office? _____

Client's Name:_____

Currently living: Home: _____ Nursing Home or ALF:_____ Admission Date:_____

Home or facility address:_____

City:_____ County:_____ State:_____ Zip:_____

Telephone:_____ U.S. Citizen:_____ yes _____no

Date of Birth:_____ Social Security Number:_____

Military Service:_____ yes _____no Dates of Service:_____

Spouse's Name:_____

Currently living: Home: _____ Nursing Home or ALF:_____ Admission Date:_____

Home or facility address:_____

City:_____ County:_____ State:_____ Zip:_____

Home:_____ Cell:_____ Work:_____

E-mail:_____ U.S. Citizen:_____ yes _____no

Date of Birth:_____ Social Security Number:_____

Military Service:_____ yes _____no Dates of Service:_____

CONTACT PERSON (if different from spouse)

Contact Name:_____ Relationship to Client:_____

Address:_____

City:_____ County:_____ State:_____ Zip:_____

Home:_____ Cell:_____ Work:_____

Fax:_____ E-mail:_____

Date of Birth:_____ Social Security Number:_____

Name of person to be billed:_____

GENERAL INFORMATION ABOUT THE CLIENT

Are you currently: _____ Married _____ Widowed _____ Divorced _____ Single

If married, is this a first marriage? _____ Yes _____ No

If no, identify number of prior marriages: _____ Client _____ Spouse

Date of current marriage: _____

Is there a prenuptial agreement? _____ Yes _____ No

Do you own your home? _____ Is there a mortgage? _____ What is the mortgage balance? _____

If you sold your home what price would you expect to get for your home? _____

Is anyone in the client's family disabled? If so, whom: _____

Are there any children of this marriage? _____Yes _____No

Please list the names, addresses and all telephone numbers of all children and indicate whether they are the husband's children (H), the wife's children (W), or children of both (B). Please note if any children have died leaving children of their own (grandchildren).

_____

_____

_____

_____

_____

Medical Supplemental Insurance Carrier: _____

Coverage of Client: _____ Spouse: _____

Policy Number: _____

Monthly Premium: _____

Long Term Health Care Insurance Carrier: _____

Coverage for Client: _____ Spouse: _____

Benefit amount per day: _____ Elimination period: _____

Coverage period in years: _____

Do you have a Will? _____Yes _____No If yes, what is the date: _____

Where will the Will be kept? _____

Who is the Personal Representative? _____

Did you create a Revocable Living Trust? _____Yes _____No If yes, what is the date: _____

Where is the Trust kept? _____

Who is/are the Trustee(s)? _____

Are you the beneficiary of trust agreement(s) created by someone else? ____Yes____No

If yes, who established the trust?_____

Please attach a copy of the trust agreement.

Do you have a Health Care Directive/Living Will? ____Yes _____No If yes, what is the date?_____

Who have you named as your health care decision maker(s)? _____

Do you have a Durable Power of Attorney?_____Yes _____No If yes, what is the date? _____

Who is designated as your Agent(s)?_____

INCOME

Please list **ALL** amounts of **GROSS** monthly income which apply:

CLIENT	**SPOUSE**
Work Earnings _____	Work Earnings _____
SS Retirement _____	SS Retirement _____
SS Disability _____	SS Disability _____
Veterans Benefits _____	Veterans Benefits _____
Pension _____	Pension _____
Annuity _____	Annuity _____
Rental Income _____	Rental Income _____
Interest & Dividends _____	Interest & Dividends _____
Other _____	Other _____

ASSETS

Please give an estimated value of the following assets, excluding your home.

	CLIENT	**SPOUSE**	**JOINT**
Checking & Savings	_____	_____	_____
Stocks, Bonds, &/or Mutual funds:	_____	_____	_____
IRA'S:	_____	_____	_____
Non-homestead Real Estate:	_____	_____	_____
Other	_____	_____	_____

GIFTS TO SOMEONE OTHER THAN A SPOUSE WITHIN THE PAST 36 MONTHS

Type of Asset: _____ Date of Gift: _____ Amount: _____

Type of Asset: _____ Date of Gift: _____ Amount: _____

Type of Asset: _____ Date of Gift: _____ Amount: _____

What is current mental and physical health of the client? _____

_____

_____

What is the current mental and physical health of the spouse? _____

_____

_____

Do you anticipate the need to place client in a long term care facility within the next 12 months? If so, when?

_____

Do you have professional advisors?

	NAME	CITY	PHONE
CPA			
Insurance Advisor			
Financial Advisor			
Banker			
Spiritual Advisor			

Any additional information you feel we should know about the client and/or family: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature