





### 3. HEALTH RELATED PROBLEMS

<u>Husband</u>		<u>Wife</u>	
<input type="checkbox"/> is in reasonably good health <input type="checkbox"/> suffers from (specify diagnosis)		<input type="checkbox"/> is in reasonably good health <input type="checkbox"/> suffers from (specify diagnosis)	
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Heart Attack (effect of previous)	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Heart Attack (effect of previous)
<input type="checkbox"/> Arterial Fibrillation	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Arterial Fibrillation	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hip Fracture (effects of)	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hip Fracture (effects of)
<input type="checkbox"/> Bedsores	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Bedsores	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cancer	<input type="checkbox"/> Knee Surgery (effects of)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Knee Surgery (effects of)
<input type="checkbox"/> Carotid Arteries	<input type="checkbox"/> Krohn's Disease	<input type="checkbox"/> Carotid Arteries	<input type="checkbox"/> Krohn's Disease
<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Lung Cancer
<input type="checkbox"/> Cholesterol (high)	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Cholesterol (high)	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> COPD	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> COPD	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Delirium	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Delirium	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Dementia	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Dementia	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Depression	<input type="checkbox"/> Quadruple Bypass	<input type="checkbox"/> Depression	<input type="checkbox"/> Quadruple Bypass
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Spinal Stenosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Spinal Stenosis
<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Stroke (effects of prior)	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Stroke (effects of prior)
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Frailty Resulting from age	<input type="checkbox"/> Other	<input type="checkbox"/> Frailty Resulting from age	<input type="checkbox"/> Other

### 4. CAPACITY

(Are there any problems with client's memory or understanding?)

Husband: Y\_\_\_\_ N\_\_\_\_

Able to sign name: Y\_\_\_\_ N\_\_\_\_

Wife: Y\_\_\_\_ N\_\_\_\_

Able to sign name: Y\_\_\_\_ N\_\_\_\_

**5. PHYSICIAN**

Husband's \_\_\_\_\_ Specialty \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Wife's \_\_\_\_\_ Specialty \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**6. NURSING HOME COSTS**

<b>COST OF NURSING HOME</b>		
<b>Monthly Costs for Nursing Home Care</b>		
Name of Facility		
Facility Cost		
Prescription Cost		
Incontinent Cost		
Medical Insurance Cost for Client		
Are there any other Costs		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If other costs:</b>		
<b>Other Non-shelter Expenses</b>		
	<b>Description of Expenses</b>	<b>Amount</b>
1.		
2.		
3.		
4.		
5.		
6.		
<b>Total</b>		

**7. RESIDENCE - - OWNED**

(If none, go to #7)

Owned: Yes \_\_\_\_\_ No \_\_\_\_\_

a. Owner(s): \_\_\_\_\_

b. Estimated Fair Market Value (FMV):\$ \_\_\_\_\_

Mortgage: \_\_\_\_\_

c. When Purchased: \_\_\_\_\_ Purchase Price: \$ \_\_\_\_\_

- d. Purchase Costs (title & escrow fees, real estate agent commissions etc.) \_\_\_\_\_
- e. Any improvements to house? \_\_\_\_\_. If so, give value: \$ \_\_\_\_\_
- f. Single Family: Yes \_\_\_\_\_ No \_\_\_\_\_  
 If no, then # of units: \_\_\_\_\_
- g. Selling Costs (Title and escrow fees, Real Estate Agent Commissions etc.) \_\_\_\_\_
- h. Accumulated Depreciation: \_\_\_\_\_
- i. Cost Basis: \$ \_\_\_\_\_
- j. Amount of Unified Credit: \$ \_\_\_\_\_
- k. Has client owned property for 2 of the last 5 years? Yes \_\_\_\_\_ No \_\_\_\_\_
- l. Has client occupied the property for 2 of the last 5 years? Yes \_\_\_\_\_ No \_\_\_\_\_
- m. If other owner is a child, has that child lived in the residence for at least 2 years?  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 If so, has the child provided personal care - care that might have kept the parent(s) out of Long Term Care (LTC) - to the parent(s)? Yes \_\_\_\_\_ No \_\_\_\_\_
- n. If other owner is a brother or sister, has that brother or sister lived in the house for at least 1 year?  
 Yes \_\_\_\_\_ No \_\_\_\_\_
- o. Does the LTC spouse (or potential LTC spouse) have a minor or disabled child?  
 Yes \_\_\_\_\_ No \_\_\_\_\_
- p. If in or about to enter LTC, does the LTC spouse intend to return home?  
 Yes \_\_\_\_\_ No \_\_\_\_\_  
 How was this determined: \_\_\_\_\_
- q. Money owed (loan) on property: \$ \_\_\_\_\_  
 Monthly payments: \$ \_\_\_\_\_
- r. Reverse Annuity Mortgage (RAM) on property? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If so, basic terms: \_\_\_\_\_

s. Has owner(s) used \$250,000 or \$500,000 capital gains tax exclusion?  
Yes \_\_\_\_\_ No \_\_\_\_\_

**8. RESIDENCE - - RENTED**

a. Monthly cost \_\_\_\_\_

b. Nature of rental  
Single Family \_\_\_\_\_ Apartment \_\_\_\_\_  
Residential Care \_\_\_\_\_ Life Care \_\_\_\_\_  
Senior Housing \_\_\_\_\_ Subsidized? Yes \_\_\_ No \_\_\_

**9. LONG-TERM CARE (LTC)**

Is one spouse receiving LTC? Y \_\_\_ N \_\_\_  
Husband \_\_\_\_\_ or Wife \_\_\_\_\_

If so, date of entry (if home care, date started): \_\_\_\_\_

Name of LTC facility or provider: \_\_\_\_\_

Address: \_\_\_\_\_

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

Administrator (contact person and position): \_\_\_\_\_

Is it a Medicaid-certified facility? Yes \_\_\_\_\_ No \_\_\_\_\_

**10. HOSPITAL**

Is one spouse in a hospital? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, for how long? \_\_\_\_\_

Reason: \_\_\_\_\_

Convalescence in LTC expected? Yes \_\_\_\_\_ No \_\_\_\_\_

If LTC placement expected, likely to later return home? Yes \_\_\_\_\_ No \_\_\_\_\_

**11. INCOME**

Whose "Name on Check"

a.	<u>Fixed Monthly</u>	<u>Husband</u>	<u>Wife</u>	<u>Terminate on death of Recipient?</u>
				Y/N
Sources:	Social Security	\$ _____	_____	_____
	R.R. Retirement	\$ _____	_____	_____
	Medicaid Part B			
	Deduction	\$ _____	_____	_____
	Medicaid Part D	\$ _____	_____	_____
	Pension (_____)	\$ _____	_____	_____
	Employment	\$ _____	_____	_____
	Disability	\$ _____	_____	_____
	Annuity	\$ _____	_____	_____
	Rental	\$ _____	_____	_____
	Other (_____)	\$ _____	_____	_____
	Other (_____)	\$ _____	_____	_____
	Other (_____)	\$ _____	_____	_____
	Other (_____)	\$ _____	_____	_____
	Totals:	\$ _____	_____	_____

Total of Both: \$ \_\_\_\_\_

b.	<u>Non-Fixed Monthly</u>	<u>Husband</u>	<u>Wife</u>	<u>Husband &amp; Wife</u>
Sources:	Interest	\$ _____	_____	_____
	Dividends	\$ _____	_____	_____
	Other	\$ _____	_____	_____
	Other	\$ _____	_____	_____
	Totals:	\$ _____	_____	_____

Total of All: \$ \_\_\_\_\_

c.	<u>Annuity</u>	<u>Husband</u>	<u>Wife</u>
	Amount	_____	_____
	Survivorship Rights	_____	_____

**12. ASSET INVENTORY AND DETAILS**

**COUNTABLE ASSETS** (use back of form if necessary)

**CHECKING**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**SAVINGS**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**MONEY MARKET**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**SAVINGS CERTIFICATES**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**AUTOMOBILE**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**OTHER REAL ESTATE**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**BROKERAGE/CAP ACCOUNTS**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**MUTUAL FUNDS**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**STOCKS**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**BONDS**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**ANNUITIES**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**CASH VALUE LIFE INS.**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**TRADITIONAL IRA**

<b>Item</b>	<b>Value</b>	<b>Liability</b>

**ROTH IRA**

Item	Value	Liability

**RETIREMENT ACCOUNTS**

Item	Value	Liability

**OTHER**

Item	Value	Liability

**TOTAL COUNTABLE ASSETS**

	Value	Liability

**13. REAL PROPERTY**

Description and Location	How Title is Held*	Cost or Basis	Encumbrances (Liens)	Market Value
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

\*Explanation of shared ownership: \_\_\_\_\_

Any inherited? Specify: \_\_\_\_\_

**14. CHECKLIST OF EXEMPT ASSETS**

	Husband	Wife
- Burial plot owned	_____	_____
- Burial Trust/Life Insurance (\$1,500)	_____	_____
- Automobile Y_____ N _____	_____	_____

- All furnishings allowed \_\_\_\_\_
- Cash, etc. \_\_\_\_\_
- a) \$3,350 for LTC individual
- b) \$4,850 for couple needing Medicaid home care
- c) \$74,820- for community spouse (other in nursing home)

**15. OTHER ASSETS**

a) Partnerships (State if general or limited)

	<u>Basis</u>	<u>FMV</u>	<u>Whose Name(s)</u>
i)			
ii)	_____		
iii)			

b) Businesses

	<u>Name on Assets</u>	<u>Bank Value</u>
<u>FMV</u>	\$ _____	\$ _____
Explain _____		
_____		

c) Promissory Notes, 1st or 2nd mortgages, etc., payable to you.

	<u>Name(s)</u>	<u>Value</u>
i)		
ii)	_____	
iii)	_____	

d) Life Insurance

<b>FIRST POLICY</b>	
Name of Company	
Policy Number	
Address of Company	
Phone Number	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

<b>SECOND POLICY</b>	
Name of Company	
Policy Number	
Address of Company	
Phone Number	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

<b>THIRD POLICY</b>	
Name of Company	
Policy Number	
Address of Company	
Phone Number	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

<b>FOURTH POLICY</b>	
Name of Company	
Policy Number	
Address of Company	
Phone Number	
Type of Insurance Policy	
Owner of Policy	
Insured Life	
Beneficiary	
Death Benefit (\$)	
Face Value (\$)	
Cash Value (\$)	

h) Beneficiaries of Trusts (indicate value, assets, distributions available or expected)

Husband: \_\_\_\_\_

\_\_\_\_\_

Wife: \_\_\_\_\_

\_\_\_\_\_

i) Other Assets (explain, indicate how held, and value)

Husband: \_\_\_\_\_

\_\_\_\_\_

Wife: \_\_\_\_\_

\_\_\_\_\_

Joint: \_\_\_\_\_

\_\_\_\_\_

j) Expected Inheritances

Husband: \_\_\_\_\_

\_\_\_\_\_

Wife: \_\_\_\_\_

\_\_\_\_\_

**16. ASSETS OUTSIDE OF NEW YORK STATE**

List all such assets giving nature and value:

\_\_\_\_\_

\_\_\_\_\_

**17. INTEREST PARTIES**

**CHILDREN**

<b>FIRST CHILD</b>	
<b>Details on Child</b>	
Name of Child	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both <input type="checkbox"/> Client only <input type="checkbox"/> Spouse Only
Is Child a minor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Contact Info and Address</b>	
Do you know where the Child Lives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you know where Child lives,	<input type="checkbox"/> Use Client's Address <input type="checkbox"/> Use Spouse's Address (if different address from client) <input type="checkbox"/> Other Address/Lives Separately
Enter Address	
<b>Elder Law Specific Details</b>	
Relation to Community Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of Wedlock
Relation to Client	<input type="checkbox"/> National Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock
Work Telephone	
Home Telephone	
Cell	
Fax	
Email	
Special Details about Child	<input type="checkbox"/> Disinherit child and exclude from the plan <input type="checkbox"/> Child is an Affiant <input type="checkbox"/> Child will be a caregiver
Child is (check all that apply)	<input type="checkbox"/> Stepchild <input type="checkbox"/> Disabled <input type="checkbox"/> Minor <input type="checkbox"/> Blind
Child's problems (check all that apply)	<input type="checkbox"/> Poor Health <input type="checkbox"/> AIDS <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Alcoholism <input type="checkbox"/> Spendthrift

Government Entitlements	
Is child receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

<b>SECOND CHILD</b>	
<b>Details on Child</b>	
Name of Child	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both <input type="checkbox"/> Client only <input type="checkbox"/> Spouse Only
Is Child a minor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Contact Info and Address</b>	
Do you know where the Child Lives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you know where Child lives,	<input type="checkbox"/> Use Client's Address <input type="checkbox"/> Use Spouse's Address (if different address from client) <input type="checkbox"/> Other Address/Lives Separately
Enter Address	
<b>Elder Law Specific Details</b>	
Relation to Community Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of Wedlock
Relation to Client	<input type="checkbox"/> National Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock
Work Telephone	
Home Telephone	
Cell	
Fax	
Email	
Special Details about Child	<input type="checkbox"/> Disinherit child and exclude from the plan <input type="checkbox"/> Child is an Affiant <input type="checkbox"/> Child will be a caregiver
Child is (check all that apply)	<input type="checkbox"/> Stepchild <input type="checkbox"/> Disabled <input type="checkbox"/> Minor <input type="checkbox"/> Blind
Child's problems (check all that apply)	<input type="checkbox"/> Poor Health

	<input type="checkbox"/> AIDS <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Alcoholism <input type="checkbox"/> Spendthrift
Government Entitlements	
Is child receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

<b>THIRD CHILD</b>	
<b>Details on Child</b>	
Name of Child	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both <input type="checkbox"/> Client only <input type="checkbox"/> Spouse Only
Is Child a minor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Contact Info and Address</b>	
Do you know where the Child Lives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you know where Child lives,	<input type="checkbox"/> Use Client's Address <input type="checkbox"/> Use Spouse's Address (if different address from client) <input type="checkbox"/> Other Address/Lives Separately
Enter Address	
<b>Elder Law Specific Details</b>	
Relation to Community Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of Wedlock
Relation to Client	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock
Work Telephone	
Home Telephone	
Cell	
Fax	
Email	
Special Details about Child	<input type="checkbox"/> Disinherit child and exclude from the plan <input type="checkbox"/> Child is an Affiant <input type="checkbox"/> Child will be a caregiver
Child is (check all that apply)	<input type="checkbox"/> Stepchild

	<input type="checkbox"/> Disabled <input type="checkbox"/> Minor <input type="checkbox"/> Blind
Child's problems (check all that apply)	<input type="checkbox"/> Poor Health <input type="checkbox"/> AIDS <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Alcoholism <input type="checkbox"/> Spendthrift
Government Entitlements	
Is child receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

<b>FOURTH CHILD</b>	
<b>Details on Child</b>	
Name of Child	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	
Child is the child of	<input type="checkbox"/> Both <input type="checkbox"/> Client only <input type="checkbox"/> Spouse Only
Is Child a minor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Contact Info and Address</b>	
Do you know where the Child Lives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you know where Child lives,	<input type="checkbox"/> Use Client's Address <input type="checkbox"/> Use Spouse's Address (if different address from client) <input type="checkbox"/> Other Address/Lives Separately
Enter Address	
<b>Elder Law Specific Details</b>	
Relation to Community Spouse	<input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of Wedlock
Relation to Client	<input type="checkbox"/> National Child <input type="checkbox"/> Adopted <input type="checkbox"/> Stepchild <input type="checkbox"/> Child born out of wedlock
Work Telephone	
Home Telephone	
Cell	
Fax	
Email	

Special Details about Child	<input type="checkbox"/> Disinherit child and exclude from the plan <input type="checkbox"/> Child is an Affiant <input type="checkbox"/> Child will be a caregiver
Child is (check all that apply)	<input type="checkbox"/> Stepchild <input type="checkbox"/> Disabled <input type="checkbox"/> Minor <input type="checkbox"/> Blind
Child's problems (check all that apply)	<input type="checkbox"/> Poor Health <input type="checkbox"/> AIDS <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Alcoholism <input type="checkbox"/> Spendthrift
Government Entitlements	
Is child receiving SSI or another form of government entitlement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, entitlement from	
If yes, specify monthly payment	

**RELATIONS and OTHER PARTIES**

<b>FIRST CONTACT</b>	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	
Work Telephone	
Home Telephone	
Fax	
E-mail	
SSN	

<b>SECOND CONTACT</b>	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	
Work Telephone	
Home Telephone	
Fax	
E-mail	
SSN	

<b>THIRD CONTACT</b>	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	
Work Telephone	
Home Telephone	
Fax	
E-mail	
SSN	

<b>FOURTH CONTACT</b>	
Name	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	
Relation to Spouse	
Street Address	

Work Telephone	
Home Telephone	
Fax	
E-mail	
SSN	

**19. RESPONSIBLE PERSONS**

Who now has "assistance" responsibilities?

For Husband: First:\_\_\_\_\_

Alternate:\_\_\_\_\_

For Wife: First:\_\_\_\_\_

Alternate:\_\_\_\_\_

**20. OTHER ISSUES**

<b>OTHER ISSUES</b>		
Do you have any other legal issues which I should be aware of?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, list the issues below</b>		
	<b>Issue</b>	<b>Importance</b>
1.		<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
2.		<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
3.		<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
4.		<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
5.		<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry

**21. COST OF LIVING (EST.) PER MONTH**

	Husband	Wife	Both
a) Housing	_____	_____	
If own, mortgage, taxes, etc.*	_____	_____	
If rent, rental	_____	_____	

b) Insurance			
Health	_____	_____	_____
LTC	_____	_____	_____
Life	_____	_____	_____
Other	_____	_____	_____
c) Health and Medications	_____	_____	_____
d) Food	_____	_____	_____
e) Entertainment and travel	_____	_____	_____
f) Support for child(ren)	_____	_____	_____
g) Other	_____	_____	_____
 TOTALS	_____	_____	_____

**22. SECOND MARRIAGE OF ILL SPOUSE?**

Is this the second marriage for ill spouse? Yes \_\_\_\_ No \_\_\_\_

If so, what is the relationship with ex-spouse?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

**23. HEALTH AND LTC INSURANCE**

(Use back of form if necessary)

	<u>Husband</u>	<u>Wife</u>
Health	_____	_____
Medicare Supplement	_____	_____
Long-Term Care	_____	_____
Other	_____	_____

**24. PLANNING AND OTHER DOCUMENTS**

		<u>Husband (year)</u>	<u>Wife (year)</u>
a)	Will		
	Have originals?      Y__ N__	_____	_____
	Copies?                Y__ N__		
b)	Trust, Revocable	_____	_____
	Copies?                Y__ N__		
c)	Durable Power of Atty.	_____	_____
	If so, Statutory Form? Y__ N__		
d)	Health Care Proxy.	_____	_____
	Living Will	_____	_____
e)	Deed(s) and		
	Property Tax Statement(s)?	_____	
	Copies?                Y__ N__		

**25. GIFTS**

Has either spouse given Gifts of \$10,000 or more over the past 10 years to Family Member(s)?  
 Y\_\_\_\_\_ N\_\_\_\_\_

If so,

<u>Recipient</u>	<u>Amount</u>	<u>Year</u>
_____		
_____		

Gift tax returns filed on any gifts?    Y\_\_\_\_\_ N\_\_\_\_\_

If so, which? \_\_\_\_\_

**26. TRANSFERS WITHIN 36 MONTHS**

Has either spouse transferred property to anyone other than wife/husband within the last 36 months?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so,

<u>Recipient</u>	<u>Amount</u>	<u>Date (mo. &amp; yr.)</u>
------------------	---------------	-----------------------------

_____		
_____		
_____		

**25. GOALS OF CLIENT**

Person responding:\_\_\_\_\_

State goals:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_