

# ELDER LAW & DISABILITY PLANNING QUESTIONNAIRE

## Booth Harrington & Johns of NC PLLC

The information requested in this questionnaire is for use by our law firm to devise a plan of asset preservation and/or Medicaid eligibility unique to your situation. We ask that you complete the questionnaire with as much detail as possible. The information that you disclose is confidential and is not shared with anyone outside this Firm, with the possible exception of the Department of Social Services at the filing of Medicaid application.

Date \_\_\_\_\_

By whom were you referred to this office? \_\_\_\_\_

### 1. PERSONAL INFORMATION

(The person for whom you are seeking elder law legal advice)

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_

#### Husband or Individual (living or deceased)

Full Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address (street/city/state/zip) \_\_\_\_\_

How long at this address? \_\_\_\_\_ Current Age: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ US Citizen? Yes  No

City, County, State of Birth \_\_\_\_\_

Are you a Veteran? Yes  No  Service Branch \_\_\_\_\_ Date of Death, if applicable \_\_\_\_\_  
If yes, contact the Department of Veteran's Affairs at 1-800-827-1000.

#### Wife or Individual (living or deceased) [If Applicable]

Full Name (include maiden) \_\_\_\_\_ Phone No. \_\_\_\_\_

Address (street/city/state/zip) \_\_\_\_\_

How long at this address? \_\_\_\_\_ Current Age: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ US Citizen? Yes  No

City, County, State of Birth \_\_\_\_\_

Are you a Veteran? Yes  No  Service Branch \_\_\_\_\_ Date of Death, if applicable \_\_\_\_\_

Reviewed by Intake Asst \_\_\_\_\_

**Contact and Correspondence Information (if more than one recipient, please list on back)**

Name \_\_\_\_\_

Address (street/city/state/zip) \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address (if applicable) \_\_\_\_\_

**2. HEALTH AND NURSING HOME INFORMATION**

Name of Ill Person or Spouse \_\_\_\_\_

Diagnosis \_\_\_\_\_

Prognosis \_\_\_\_\_

Name of Well Spouse (If applicable) \_\_\_\_\_

Health Status of Well Spouse \_\_\_\_\_

Where Well Spouse Currently Resides \_\_\_\_\_

**If the individual or spouse entered nursing home from the hospital, please complete the following chart:**

Hospital	Date Admitted	Date Discharged
1.		
2.		
3.		

**OR**

**If the individual or spouse entered nursing home from the home, please complete the following chart:**

Nursing Home	Date Admitted	Date Discharged
1.		
2.		
3.		

**\*\*PLEASE NOTE: If a spouse has entered a nursing home or hospital, PLEASE BRING A COPY OF THE CURRENT FL-2 FORM TO OUR CONFERENCE. This is important to have at the conference.**

Has either spouse ever filed an application for Medicaid benefits with the Department of Social Services?

Yes  No

If yes, date of application \_\_\_\_\_

### 3. CHILDREN (IF APPLICABLE)

Number of Children \_\_\_\_\_

Name of Child and Their Spouse	Address With ZIP Code	Telephone Number	Date of Birth

Use Separate Sheet to list additional children

### 4. MONTHLY INCOME

	Monthly Income	Monthly Income of Spouse (If Applicable)
Gross Salary or Wages	\$ _____	\$ _____
Social Security Benefits (include \$96.40 or \$110.50 Medicare Part B Deduction, if applicable)	\$ _____	\$ _____
*Medicare Part D Premium	\$ _____	\$ _____
**Retirement/Pension Benefits (Gross) (include any withholdings for taxes and/or benefit of any kind)	\$ _____	\$ _____
From what company do you receive retirement benefits?	_____	
VA Disability Benefit (including any survivor's benefits)	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Dividend	\$ _____	\$ _____
Other (Do not include interest income)	\$ _____	\$ _____
<b>TOTAL INCOME</b>	<b>\$ _____</b>	<b>\$ _____</b>

\*If you have questions about Medicare Part D, please call or visit your local Social Security Agency.

\*\*Could your pension amount increase in the future? Yes  No

## 5. ASSETS

Please insert the approximate value of each asset/liability in the appropriate space. List Banks and Accounts numbers wherever possible:

ASSETS	ACCT TYPE <sup>1</sup>	HUSBAND/ INDIVIDUAL	WIFE/ INDIVIDUAL	JOINT	LIABILITIES
BANKING ACCOUNT					
BANKING ACCOUNT					
BANKING ACCOUNT					
BANKING ACCOUNT					
RESIDENCE (ASSESSED TAX VAL)					
OTHER REAL ESTATE (TAX VAL)					
AUTOMOBILE(S)					
MUTUAL FUNDS					
STOCKS					
BONDS					
ANNUITIES					
*CASH VALUE - WHOLE LIFE INS.					
IRA					
401K OR OTHER RET. PLANS					
NURSING HOME PATIENT ACCT					
PREPAID FUNERAL CONTRACT					
PREPAID BURIAL PLOT(S)					
OTHER					
<b>TOTALS</b>					

Use additional sheets, if necessary

\*Detail on Page 6.

<sup>1</sup> Type of Banking Account – CK-Checking; SV-Savings; MM-Money Market; CD-Certificate of Deposit - If any of your bank accounts are joint with children, please so indicate. If the bank account is "OR," please write "OR" next to account. If the account is "AND," please indicate by writing "AND."

## 6. GIFTS

Gifts made in the last 5 years, having a value of \$500.00 or more (i.e. cash, real estate, automobiles, even if given as Christmas or Birthday gifts). If unsure, list all gifts. (This includes Christmas gifts of cash, gifts to individuals, churches, educational institutions, charities, etc.)

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \$ \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \$ \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \$ \_\_\_\_\_

Have you ever filed a Federal Gift Tax Return? Yes  No  If yes, please provide a copy.

## 7. HOMEPLACE

Current value (what could it sell for?): \$ \_\_\_\_\_

Mortgage balance \$ \_\_\_\_\_

Year of purchase of home: \_\_\_\_\_

Is your home or other property used as a business or farm? Yes  No

Have you sold or gifted your home place within the last five years? Yes  No

## 8. LEGAL DOCUMENTS

Does anyone reside in your home or other property owned by you? Yes  No

If so, please explain \_\_\_\_\_

Do you have a current Will? Yes  No  *A will is a written document which leaves the estate of the person who signed the will to named persons or entities.*

Do you currently have a Durable Power of Attorney? Yes  No  *A durable power of attorney is a document designating an individual as having the authority to perform certain specific acts on behalf of another, irrespective of physical or mental state.*

Do you currently have a Living Will? Yes  No  *A living will is a document which governs the withholding or withdrawal of life-sustaining treatment from an individual in the event of an incurable or irreversible condition that will cause death within a relatively short time and when such person is no longer able to make decisions regarding his or her medical treatment.*

Do you have a Health Care Power of Attorney? Yes  No  *A health care power of attorney is a document in which the patient designates a person who has legal authority to make medical decisions for that patient who is too incapacitated to make such decisions.*

**9. LIFE INSURANCE**

**It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.**

<b>COMPANY (include Address and Policy Number)</b>	<b>TYPE</b>	<b>DEATH BENEFIT VALUE</b>	<b>FACE VALUE</b>	<b>CASH VALUE</b>	<b>INSURED</b>	<b>OWNER</b>	<b>BENEFICIARY</b>

**Medicare Supplemental Insurance**

**Company**

**Policy Number**

**Premium**

**Are these premiums paid from your retirement check?**

For Husband/Individual

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes  No

For Wife/Individual

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes  No

**Medicare Part D Insurance**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes  No

**Long-Term Care Insurance**

**Company**

**Policy Number**

**Premium**

**Are these premiums paid from your retirement check?**

For Husband

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes  No

For Wife

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes  No

## 10. MISCELLANEOUS

Do you have any other legal issues of which we should be aware? If yes, please explain. Use separate sheet if necessary.

Do you have a safe deposit box? Yes  No

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It is important that the above information be as accurate as possible. This information helps the attorney to give you the best possible information in your conference.

Please bring to your conference the Powers of Attorney, as well as the current **FL-2 Form (relating to level of patient care)**, if applicable.

## 11. CERTIFICATION

The undersigned hereby each represents to Booth Harrington & Johns of NC PLLC, 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 that I am furnishing. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

**Signature of Clients or Client Representative:**

  

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