LAW OFFICE OF
ANTONY M. EMINOWICZ PLLC
Wills, Trusts and Medicaid Asset Protection

Long Term Care Planning Questionnaire

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PART A: PERSONAL INFORMATION

Client:

Full Name

Address

Home Phone

Cell Phone

U.S. Citizen Yes No

Date of Birth

Social Security

General Health Information

List Date(s) and Location of Hospitalization(s) During the Past Year

Spouse:

U.S. Citizen Yes No

PART A: PERSONAL INFORMATION

Client:

Medicare Yes ☐ No ☐

Veteran Yes ☐ No ☐

Spouse:

Medicare Yes ☐ No ☐

Veteran Yes ☐ No ☐

Major Medical or Other Health Insurance & Monthly Payment

Long-Term Care Insurance & Monthly Payment

Children:

Name	Complete Address	Telephone Number	Age	Social Security #

Please indicate if any of the above children are of a previous marriage:

Are any of your children blind? Yes ☐ No ☐

Are any of your children disabled? Yes ☐ No ☐

Do any of your children live with you in your home? Yes ☐ No ☐

If Yes, list names:

PART B: MISCELLANEOUS INFORMATION

If either spouse is in a nursing home or contemplates entering a nursing home, please list the following:

Facility | Date of Hospitalization:

List monthly charges and source of payment at the present time:

PART C: MONTHLY INCOME

Income description	Spouse's monthly income	Spouse's monthly income	Joint monthly income
Net Salary or Wages (Take Home Pay)			
Social Security Benefits			
Retirement Benefits			
Interest			
Dividends			
Pension			
Other			
Total monthly income			

PART D: ASSETS

Please insert the approximate value of each asset/liability in the appropriate space (by owner):

Asset	Spouse	Spouse	Joint	Liability
Primary Residence				
Other Real Estate				
Automobile(s)				
Checking Account(s)				
Savings Account(s)				
Money Market Account(s)				
Certificate(s) of Deposit				
Mutual Funds				
Stocks				
Bonds				
Annuities				
Cash Surrender Value of Life Insurance				
IRA Account(s)				
Life Insurance				
Total				

Is there a safe deposit box? Yes No

If Yes, locations:

Box Number Joint Tenant or Deputy:

It is important to know the cash surrender value of your life insurance policy. To obtain the cash surrender value of the policies, please call your insurance agent, or call the insurance company directly. (Please include the cash surrender value of the life insurance listed in **Part D of this form**.)

PART E: GIFTS

Please list any gifts made by either spouse in excess of $1,000 to an individual other than your spouse within the past 60 months:

Recipient	Date	Amount

The information on the previous five (5) pages is true and accurate to the best of my knowledge.

Signature

PART F:

Please furnish our office with copies of the following documents, if applicable:

1. Deed to Home and current County Tax Bill;
2. Deed to other Real Property and County Tax Bill;
3. Copy of Last Will and Testament;
4. Copy of Power of Attorney;
5. Copy of Health Care Proxy.
6. Others - What are your goals from this meeting? i.e. I want to know how to obtain Medicaid benefits for my spouse, I want to know how I can best protect my assets should I (or my spouse) go into nursing care, I would like to discuss Veterans Benefits, etc