

# Special Needs Lawyers, PA

901 Chestnut Street, Suite C  
Clearwater, Florida 33756

Phone: (727) 443-7898

Fax: (727) 631-0970

SpecialNeedsLawyers.com

Travis D. Finchum, Esq.  
Board Certified in Elder Law

Linda R. Chamberlain, Esq.  
Board Certified in Elder Law

Charles F. Robinson, Esq.  
Board Certified in Elder Law

Kole J. Long, Esq.  
Elder Law Attorney

Special Needs Trusts | Elder Law | Long Term Care Planning | Medicaid | Probate | Wills & Trusts  
Incapacity Planning | Guardianship | Developmental Disabilities | Veteran's Benefits

## Planning questionnaire

Please print names as they would appear on legal documents.

Date \_\_\_\_\_

**Client** name \_\_\_\_\_

Spouse Name \_\_\_\_\_

Home address \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ E-mail \_\_\_\_\_

County \_\_\_\_\_ E-mail \_\_\_\_\_

Phone #s \_\_\_\_\_

Phone #s \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_

US citizen: Yes \_\_\_ No \_\_\_ If no, born in \_\_\_\_\_

US citizen: Yes \_\_\_ No \_\_\_ If no, born in \_\_\_\_\_

Naturalized citizen born in \_\_\_\_\_

Naturalized citizen born in \_\_\_\_\_

Florida resident since \_\_\_\_\_

Florida resident since \_\_\_\_\_

**Contact person** if other than Client or Spouse:

Full name \_\_\_\_\_

Address \_\_\_\_\_

Phone #s \_\_\_\_\_

Email \_\_\_\_\_

Date of marriage \_\_\_\_\_

If **deceased**, full name \_\_\_\_\_

Date of death \_\_\_\_\_

**Health of Client**

Current and past medical or health problems \_\_\_\_\_  
\_\_\_\_\_

Problems with memory or understanding: Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_  
\_\_\_\_\_

**Client is currently living:**

Home \_\_\_\_\_ Nursing home \_\_\_\_\_ ALF \_\_\_\_\_ Hospital \_\_\_\_\_

If in nursing home, ALF, or hospital:

Facility name \_\_\_\_\_ Date of admission \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Phone \_\_\_\_\_ Covered by **Hospice?** Yes \_\_\_ No \_\_\_

Expected to return home? \_\_\_\_\_

**Client physician**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

**Health of Spouse**

Current and past medical or health problems \_\_\_\_\_  
\_\_\_\_\_

Problems with memory or understanding: Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_  
\_\_\_\_\_

**Spouse is currently living:**

Home \_\_\_\_\_ Nursing home \_\_\_\_\_ ALF \_\_\_\_\_ Hospital \_\_\_\_\_

If in nursing home, ALF, or hospital:

Facility name \_\_\_\_\_ Date of admission \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Phone \_\_\_\_\_ Covered by **Hospice?** Yes \_\_\_ No \_\_\_

Expected to return home? \_\_\_\_\_

**Spouse physician**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

**Children**

Please print names as they would appear on legal documents. Copy and attach additional pages, if necessary.

Name \_\_\_\_\_ Relation to **Client** \_\_\_\_\_ Relation to **Spouse** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_ Spouse name \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Disabled: Yes \_\_\_ No \_\_\_ Special Needs \_\_\_\_\_  
 Receiving public benefits: Yes \_\_\_ No \_\_\_ Declared disabled by Social Security Administration: Yes \_\_\_ No \_\_\_  
 Deceased: Yes \_\_\_ No \_\_\_ Date of death \_\_\_\_\_ Surviving children \_\_\_\_\_

Name \_\_\_\_\_ Relation to **Client** \_\_\_\_\_ Relation to **Spouse** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_ Spouse name \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Disabled: Yes \_\_\_ No \_\_\_ Receiving public benefits: Yes \_\_\_ No \_\_\_  
 Receiving public benefits: Yes \_\_\_ No \_\_\_ Declared disabled by Social Security Administration: Yes \_\_\_ No \_\_\_  
 Deceased: Yes \_\_\_ No \_\_\_ Date of death \_\_\_\_\_ Surviving children \_\_\_\_\_

Name \_\_\_\_\_ Relation to **Client** \_\_\_\_\_ Relation to **Spouse** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_ Spouse name \_\_\_\_\_  
 Date of birth \_\_\_\_\_ Disabled: Yes \_\_\_ No \_\_\_ Receiving public benefits: Yes \_\_\_ No \_\_\_  
 Receiving public benefits: Yes \_\_\_ No \_\_\_ Declared disabled by Social Security Administration: Yes \_\_\_ No \_\_\_  
 Deceased: Yes \_\_\_ No \_\_\_ Date of death \_\_\_\_\_ Surviving children \_\_\_\_\_

**Other family members and friends**

Please print names as they would appear on legal documents. Copy and attach additional pages, if necessary.

Name \_\_\_\_\_ Relation to **Client** \_\_\_\_\_ Relation to **Spouse** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

Name \_\_\_\_\_ Relation to **Client** \_\_\_\_\_ Relation to **Spouse** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

**Family issues**

Describe any family issues \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Safe deposit box**

Name of bank, bank branch, box # \_\_\_\_\_  
Who is authorized to enter the box? \_\_\_\_\_

**Investment advisor name** \_\_\_\_\_

Company name \_\_\_\_\_

Address \_\_\_\_\_

Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

**Accountant or CPA name** \_\_\_\_\_

Company name \_\_\_\_\_

Address \_\_\_\_\_

Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

**Attorney name** \_\_\_\_\_

Address \_\_\_\_\_

Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

**Who referred you to our office?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone #s \_\_\_\_\_ E-mail \_\_\_\_\_

## Estate planning

Please provide copies of all estate planning documents and photo identification with the questionnaire.

### Client

#### Current documents

Will: Yes \_\_\_\_\_ No \_\_\_\_\_

Revocable Living Trust: Yes \_\_\_\_\_ No \_\_\_\_\_

Amendments to Revocable Living Trust: Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

Durable Power of Attorney: Yes \_\_\_\_\_ No \_\_\_\_\_

Health Care Surrogate: Yes \_\_\_\_\_ No \_\_\_\_\_

Living Will: Yes \_\_\_\_\_ No \_\_\_\_\_

Prenuptial Agreement: Yes \_\_\_\_\_ No \_\_\_\_\_

Beneficiary of trust of another person: Yes \_\_\_\_\_ No \_\_\_\_\_

#### Photo Identification

Driver's license: Yes \_\_\_\_\_ No \_\_\_\_\_

Other: Yes \_\_\_\_\_ No \_\_\_\_\_ What? \_\_\_\_\_

### Client is

- Blind: Yes \_\_\_\_\_ No \_\_\_\_\_
- Has macular degeneration or cannot read documents: Yes \_\_\_\_\_ No \_\_\_\_\_
- Declared incompetent or cannot understand documents: Yes \_\_\_\_\_ No \_\_\_\_\_
- Physically unable to write name. Would sign with an X. Yes \_\_\_\_\_ No \_\_\_\_\_

### Spouse

#### Current documents

Will: Yes \_\_\_\_\_ No \_\_\_\_\_

Revocable Living Trust: Yes \_\_\_\_\_ No \_\_\_\_\_

Amendments to Revocable Living Trust: Yes \_\_\_\_\_ No \_\_\_\_\_ How many? \_\_\_\_\_

Durable Power of Attorney: Yes \_\_\_\_\_ No \_\_\_\_\_

Health Care Surrogate: Yes \_\_\_\_\_ No \_\_\_\_\_

Living Will: Yes \_\_\_\_\_ No \_\_\_\_\_

Prenuptial Agreement: Yes \_\_\_\_\_ No \_\_\_\_\_

Beneficiary of trust of another person: Yes \_\_\_\_\_ No \_\_\_\_\_

#### Photo Identification

Driver's license: Yes \_\_\_\_\_ No \_\_\_\_\_

Other: Yes \_\_\_\_\_ No \_\_\_\_\_ What? \_\_\_\_\_

### Spouse is

- Blind: Yes \_\_\_\_\_ No \_\_\_\_\_
- Has macular degeneration or cannot read documents: Yes \_\_\_\_\_ No \_\_\_\_\_
- Declared incompetent or cannot understand documents: Yes \_\_\_\_\_ No \_\_\_\_\_
- Physically unable to write name. Would sign with an X. Yes \_\_\_\_\_ No \_\_\_\_\_

## VA Benefits

### Client

**Military service:**  Yes  No  Unsure  If yes, Branch of service \_\_\_\_\_

Active duty dates: from \_\_\_\_\_ to \_\_\_\_\_ Honorable discharge: Yes \_\_\_ No \_\_\_

Retired from military: Yes \_\_\_ No \_\_\_ Currently receiving benefits: Yes \_\_\_ No \_\_\_ Claim pending: Yes \_\_\_ No \_\_\_

VA file# \_\_\_\_\_ Monthly benefit \_\_\_\_\_ Date benefits began \_\_\_\_\_

#### **Type of benefit**

Service connected disability compensation: Yes \_\_\_\_\_ No \_\_\_\_\_ Percentage \_\_\_\_\_

Non-service connected disability pension: Yes \_\_\_\_\_ No \_\_\_\_\_

Special monthly pension based on Aid and Attendance or Housebound status: Yes \_\_\_ No \_\_\_

Enrolled in VA healthcare system: Yes \_\_\_\_\_ No \_\_\_\_\_

#### **Marriages**

How many times married? \_\_\_ Married to \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_

Marriage terminated by: Death \_\_\_ Divorce \_\_\_ Year terminated \_\_\_\_\_ Place \_\_\_\_\_

Copy and attach this page for additional marriages, if necessary.

### Spouse

**Military service:**  Yes  No  Unsure  If yes, Branch of service \_\_\_\_\_

Active duty dates: from \_\_\_\_\_ to \_\_\_\_\_ Honorable discharge: Yes \_\_\_ No \_\_\_

Retired from military: Yes \_\_\_ No \_\_\_ Currently receiving benefits: Yes \_\_\_ No \_\_\_ Claim pending: Yes \_\_\_ No \_\_\_

VA file# \_\_\_\_\_ Monthly benefit \_\_\_\_\_ Date benefits began \_\_\_\_\_

#### **Type of benefit**

Service connected disability compensation: Yes \_\_\_\_\_ No \_\_\_\_\_ Percentage \_\_\_\_\_

Non-service connected disability pension: Yes \_\_\_\_\_ No \_\_\_\_\_

Special monthly pension based on Aid and Attendance or Housebound status: Yes \_\_\_ No \_\_\_

Enrolled in VA healthcare system: Yes \_\_\_\_\_ No \_\_\_\_\_

#### **Marriages**



How many times married? \_\_\_ Married to \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_

Marriage terminated by: Death \_\_\_ Divorce \_\_\_ Year terminated \_\_\_\_\_ Place \_\_\_\_\_

Copy and attach this page for additional marriages, if necessary.

**Monthly income summary**

Gross income equals what is actually received plus any deductions. Social Security deductions may include Medicare Part B and Medicare Part D premiums. Pension deductions may include taxes, health insurance, life insurance premiums, etc. Pro-rate any quarterly or yearly payments to a **monthly** amount.

<b>Source</b>	<b>Client Gross income</b>	<b>Client Net income</b>	<b>Spouse Gross income</b>	<b>Spouse Net income</b>
Social Security	\$	\$	\$	\$
Civil Service	\$	\$	\$	\$
Retirement pensions	\$	\$	\$	\$
Military pension (DFAS)	\$	\$	\$	\$
Annuity	\$	\$	\$	\$
IRA distributions	\$	\$	\$	\$
VA benefits	\$	\$	\$	\$
Other retirement income Source	\$	\$	\$	\$
<b>Total Retirement Income</b> Estimate and enter gross retirement income amount 	\$	\$	\$	\$
Interest and dividends	\$	\$	\$	\$
Rental income	\$	\$	\$	\$
Other income Source:	\$	\$	\$	\$
<b>Total income</b> 	\$	\$	\$	\$






## Stocks, bonds, mutual funds, or other marketable securities


**DO NOT LIST SECURITIES HELD IN THE BROKERAGE ACCOUNT HERE.**

Copy and attach additional pages, if necessary.

Owner(s)	Type of Security	Number and Company	Value
Client, spouse, joint, joint/child, POD child, trust	Common stock, mutual fund, bonds	100 shares CocaCola, Evergreen Fund	\$Current balance
			\$
			\$
			\$
<b>Total</b> Stocks, bonds, mutual funds		DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$


## Annuities

Copy and attach additional pages, if necessary.

Owner	Company	Beneficiary(s)	Value	Pay outs or Premiums
Client, spouse, joint, joint/child, POD child, trust	AIG, Aviva	Spouse, children	\$100,000	Paying \$400 annually Premium \$200 monthly
			\$	\$
			\$	\$
<b>Total</b> Annuities			DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$

## US savings bonds

Copy and attach additional pages, if necessary.

Owner(s)	Type	Number and Face	Value
Client, spouse, joint, joint/child, POD child, trust	E, EE, H	15 EE	\$Current balance
			\$
<b>Total</b> US savings bonds		DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$

**Loans, mortgages, promissory notes: money due to you**


Copy and attach additional pages, if necessary.

Name(s) on the note or mortgage \_\_\_\_\_

Balance due: \$ \_\_\_\_\_


Can the mortgage be sold? Yes \_\_\_\_\_ No \_\_\_\_\_

Amount you could sell it for? \$ \_\_\_\_\_

<b>Total</b> Loans, mortgages, promissory notes			DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$
---	--	--	--	----


**Life insurance** Copy and attach additional pages, if necessary.

Company	Insured/Owner if different, list both	Beneficiary(s)	Face value	Loan amount	Cash value
Prudential	Bob Smith, owner Kay Smith, insured	Children-Rob and Kate	\$	\$	\$
			\$	\$	\$
			\$	\$	\$
			\$	\$	\$


<b>Total</b> Life insurance cash value			DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$
--	--	--	--	----


## Other assets such as REITs, Oil and Gas, Limited partnership, Time shares

Copy and attach additional pages, if necessary.

Owner(s)	Type of Asset	Number and Company	Value
Client, spouse, joint, joint/child, POD child, trust			\$
			\$
			\$
			\$
			\$
<b>Total</b> Other assets		DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$


## Cash

Owner(s)	Forms of currency	Number and Company	Value
<b>Total</b> Cash, gold coins		DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$

<b>Total</b> Available assets Add total boxes from pages 9, 10, 11, 12.		DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$
--	--	--	----

**Retirement accounts - IRA, SEP, 401(k), profit sharing, Keogh, etc.**

Copy and attach additional pages, if needed.

Owner	Company	Beneficiary(s)	Value	Distributions
			\$	\$
			\$	\$
<b>Total</b> IRAs and other retirement accounts			DO NOT LEAVE BOX BLANK  Enter dollar amount, or ? if unsure, or no for none	\$

**Real property other than home DO NOT LIST HOME HERE.**

Copy and attached additional pages, if necessary.

**Property #1** Address \_\_\_\_\_

House \_\_\_ Mobile home \_\_\_ Condominium \_\_\_ Other, describe \_\_\_\_\_

If mobile home: Own the lot \_\_\_\_\_ Rent the lot \_\_\_\_\_ Stock ownership \_\_\_\_\_

Names on the deed \_\_\_\_\_

Is there a mortgage? Yes \_\_\_ No \_\_\_ Mortgage balance? \$ \_\_\_\_\_

Most recent county property appraiser's value \$ \_\_\_\_\_

What price would you expect to receive if you sold the property? \$ \_\_\_\_\_

Date of purchase \_\_\_\_\_ Purchase price \$ \_\_\_\_\_

Is property used for business purposes? \_\_\_\_\_

Do you receive rental income? Yes \_\_\_ No \_\_\_ Monthly rental amount \$ \_\_\_\_\_

**Property #2** Address \_\_\_\_\_

House \_\_\_ Mobile home \_\_\_ Condominium \_\_\_ Other, describe \_\_\_\_\_

If mobile home: Own the lot \_\_\_\_\_ Rent the lot \_\_\_\_\_ Stock ownership \_\_\_\_\_

Names on the deed \_\_\_\_\_

Is there a mortgage? Yes \_\_\_ No \_\_\_ Mortgage balance? \$ \_\_\_\_\_

Most recent county property appraiser's value \$ \_\_\_\_\_

What price would you expect to receive if you sold the property? \$ \_\_\_\_\_

Date of purchase \_\_\_\_\_ Purchase price \$ \_\_\_\_\_

Is property used for business purposes? \_\_\_\_\_ Explain \_\_\_\_\_

Do you receive rental income? Yes \_\_\_ No \_\_\_ Monthly rental amount \$ \_\_\_\_\_

**Home**

Address \_\_\_\_\_  
 House \_\_\_\_\_ Mobile home \_\_\_\_\_ Condominium \_\_\_\_\_ Other, describe \_\_\_\_\_  
 If mobile home: Own the lot \_\_\_\_\_ Rent the lot \_\_\_\_\_ Stock ownership \_\_\_\_\_  
 Names on the deed \_\_\_\_\_  
 Is there a mortgage? Yes \_\_\_\_\_ No \_\_\_\_\_ Mortgage balance? \$ \_\_\_\_\_  
 Most recent county property appraiser's value \$ \_\_\_\_\_  
 What price would you expect to receive if you sold the home? \$ \_\_\_\_\_  
 Date of purchase \_\_\_\_\_ Purchase price \$ \_\_\_\_\_  
 Homestead exemption on property \_\_\_\_\_

**Anticipated major repairs to home**

Type of repair \_\_\_\_\_ Estimated cost \_\_\_\_\_  
 Type of repair \_\_\_\_\_ Estimated cost \_\_\_\_\_

**Monthly shelter expenses**

Mortgage/Rent (Please circle which)	\$
Real estate taxes	\$
Homeowners/Renters insurance (Please circle which)	\$
Home maintenance and upkeep	\$
Utilities	\$
Condominium fees	\$
<b>Total monthly shelter expenses</b>	\$

**Amount owed to creditors**

Credit cards	\$
Mortgage	\$
Automobile loans	\$
Other – what?	\$

**Client - Nursing home/assisted living facility expenses**

Monthly facility charges	\$
Monthly drug expenses	\$
Facility paid through what date?	

If spouse is in facility, copy page and attach.

**Vehicles including cars, boats, RVs, etc.**

Type	Year	Make/model	Owner(s)	Value
				\$
				\$
				\$
				\$

**Burial assets**

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

If yes, complete all that apply.

Name and address of cemetery and number of cemetery plots \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Burial contracts or pre-paid funeral agreements**

**Contract #1** Name of owner \_\_\_\_\_  
Name, city, state of funeral home \_\_\_\_\_

Contract is: revocable \_\_\_\_\_ irrevocable \_\_\_\_\_ Contract amount \$ \_\_\_\_\_

**Contract #2** Name of owner \_\_\_\_\_  
Name, city, state of funeral home \_\_\_\_\_

Contract is: revocable \_\_\_\_\_ irrevocable \_\_\_\_\_ Contract amount \$ \_\_\_\_\_

**Special burial bank account**

Name of bank \_\_\_\_\_ Names on account \_\_\_\_\_ Balance \$ \_\_\_\_\_



## Health insurance

**Client.** Please complete all that apply.

### Medicare

(From Medicare card) Medicare number \_\_\_\_\_ Effective date \_\_\_\_\_

\_\_\_\_\_ Medicare traditional fee for service: Part A \_\_\_\_ Part B \_\_\_\_ Part B premium\$ \_\_\_\_\_

\_\_\_\_\_ Medicare HMO: Company name \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_

\_\_\_\_\_ Medicare Plus: Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_

\_\_\_\_\_ Medicare supplement: Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_

Supplement paid for by: Individual \_\_\_\_\_ Pension deduction \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Medicare Part D drug benefit: Company \_\_\_\_\_ Premium amount\$ \_\_\_\_\_

Part D paid for by: Individual \_\_\_\_\_ Social Security deduction \_\_\_\_\_ Other \_\_\_\_\_

**Long term care insurance** Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Benefit \$ per day \_\_\_\_\_

Maximum benefit \_\_\_\_\_ Elimination period \_\_\_\_\_ If receiving, start date \_\_\_\_\_

**Other health insurance** Type \_\_\_\_\_

Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_

**Spouse.** Please complete all that apply.

### Medicare

(From Medicare card) Medicare number \_\_\_\_\_ Effective date \_\_\_\_\_

\_\_\_\_\_ Medicare traditional fee for service: Part A \_\_\_\_ Part B \_\_\_\_ Part B premium\$ \_\_\_\_\_

\_\_\_\_\_ Medicare HMO: Company name \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_

\_\_\_\_\_ Medicare Plus: Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_

\_\_\_\_\_ Medicare supplement: Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_

Supplement paid for by: Individual \_\_\_\_\_ Pension deduction \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Medicare Part D drug benefit: Company \_\_\_\_\_ Premium amount\$ \_\_\_\_\_

Part D paid for by: Individual \_\_\_\_\_ Social Security deduction \_\_\_\_\_ Other \_\_\_\_\_

**Long term care insurance** Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Benefit \$ per day \_\_\_\_\_

Maximum benefit \_\_\_\_\_ Elimination period \_\_\_\_\_ If receiving, start date \_\_\_\_\_

**Other health insurance** Type \_\_\_\_\_

Company \_\_\_\_\_ Premium\$ \_\_\_\_\_ Start date \_\_\_\_\_



**Client – Activities of daily living (ADLs)**

<b>Activity</b>	<b>Needs no help</b>	<b>Needs some help</b>	<b>Unable to do at all</b>
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using toilet			
Grooming			
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			

**Spouse – Activities of daily living (ADLs)**

<b>Activity</b>	<b>Needs no help</b>	<b>Needs some help</b>	<b>Unable to do at all</b>
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using toilet			
Grooming			
Using the telephone			
Getting out by car or public transport			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			