CONFIDENTIAL LONG TERM CARE PLANNING QUESTIONNAIRE

Date:______________________________

Residence Address:____

Residence Phone:__________________________ Business Phone:______________________________

Cell Phone: ______________________________ Email: ____________________________________

	Husband or Single Person	**Wife**
Full Legal Name		
Former/Other Name		
Form of Address	Mr. Miss. Ms. Mrs. Dr. Rev.	Miss. Ms. Mrs. Dr. Rev.
SS No.		
Birth date		
Birthplace		
Citizenship		
Occupation		
Employer		

FORMER MARRIAGE(S)			
Former Spouse Name			
S.S. No. of Former Spouse			
Date of Marriage			
Date of Divorce or Death			
Copy of Dissolution Papers	☐ Provided to attorney ☐ I do not have a copy ☐ I will get a copy & provide	☐ Provided to attorney ☐ I do not have a copy ☐ I will get a copy & provide	☐ Provided to attorney ☐ I do not have a copy ☐ I will get a copy & provide

CHILDREN OF THIS MARRIAGE (including adopted children)	
Name:	DOB:
Name:	DOB:
Name:	DOB:
Name:	DOB:

HUSBAND'S CHILDREN OF FORMER MARRIAGE(S)		
Name:	Parents:	DOB:
Name:	Parents:	DOB:
Name:	Parents:	DOB:

HUSBAND'S SIBLINGS/ OTHER FAMILY MEMBERS	City/ State
Name:	
Name:	
Name:	

WIFE'S CHILDREN OF FORMER MARRIAGE(S)		
Name:	Parents:	DOB:
Name:	Parents:	DOB:
Name:	Parents:	DOB:

WIFE'S SIBLINGS/ OTHER FAMILY MEMBERS	City/ State
Name:	
Name:	
Name:	

ADVISORS

TITLE	NAME	ADDRESS	TELEPHONE
Primary Personal Bank			
Life Insurance Agent			
Stock Broker			
CPA			
Other Financial Advisor			
Doctor			
Clergy			
Referred to our firm by			

Important Family Questions:

1. Do you have a child who is blind or disabled? ☐ Yes ☐ No
2. Do any of your family receive governmental support or benefits? ☐ Yes ☐ No
   If so, what types ____
3. Do you have adopted children? ☐ Yes ☐ No
4. Do any of your children have special education, medical, or physical needs? ☐ Yes ☐ No
5. Do any of your family members have bad debts or creditor problems? ☐ Yes ☐ No
6. Do any of your children have children who may be applying for financial aid for college? ☐ Yes ☐ No
7. Are any of your children institutionalized? ☐ Yes ☐ No
8. Are you or your spouse receiving social security, disability, or other governmental benefits? ☐ Yes ☐ No
9. Is anyone (other than your spouse) dependent on you for support? ☐ Yes ☐ No
10. Have any of your children or brothers or sisters lived with you during the last two years? ☐ Yes ☐ No
11. Have either of you been divorced? ☐ Yes ☐ No
12. Are you making payments pursuant to a divorce or property settlement agreement? ☐ Yes ☐ No
13. Have you and your spouse ever signed a pre-or post-marriage contract? ☐ Yes ☐ No
    (Please furnish a copy)
14. Have you or your spouse been widowed? *(If a federal estate tax return or a state death tax return was filed, please furnish a copy)* ☐ Yes ☐ No
15. Have you and your spouse lived in a state other than North Carolina during your marriage? ☐ Yes ☐ No
    If so, what states and during what periods of time did you reside there?
    ____
    ____
16. Have you or your spouse ever made any substantial gifts or filed federal or state gift tax returns? (*Please furnish copies of these returns)* ☐ Yes ☐ No
17. Have you or your spouse completed previous wills, trusts, powers of attorney or other estate planning arrangements? *(Please furnish copies of these documents)* ☐ Yes ☐ No
18. Are both you and your spouse United States citizens? ☐ Yes ☐ No
    If you answered "No," how long have you been in the United States? ☐ Yes ☐ No
19. Are you and/or your spouse a veteran? ☐ Yes ☐ No
    If so, please provide dates of service, branch of service and whether you have a service-connected disability:
    ____
    ____
20. Do you want specific funeral arrangements? ☐ Yes ☐ No
    Specify, if applicable:____
    ____
    ____
    ____

Questions About Your Medical History or Disability

1. Are you or your spouse blind, disabled or receiving SSI? ☐ Yes ☐ No
   If yes, please explain:
   ____
   ____

2. Are you or your spouse at risk for becoming seriously ill or disabled because of a medical condition or family history? ☐ Yes ☐ No
   If yes, please explain:
   ____
   ____

3. Your Doctor's Name: ____

4. Spouse's Doctor's Name: ____

5. Have you or your spouse recently entered a hospital or skilled nursing facility? ☐ Yes ☐ No
   Name of facility: ____
   Level of Care: ICF____ or SNF_____
   Date of Admission: ______________________
   Date of Discharge: ______________________
   Diagnosis: ______________________

6. Have you or your spouse previously been in the hospital or nursing home for a combined stay of 30 days or more since September 30, 1989? Yes____ No____
   If yes, please explain giving dates and name of facility
   ____
   ____

Other Information or Comments:

____
____
____
____
____
____

MONTHLY EXPENSES

MONTHLY SHELTER EXPENSES

$________________ Rent/Mortgage
$________________ Home Equity Loan
$________________ Real Estate Taxes
$________________ Water
$________________ Sewer
$________________ Utilities (heat, electric, phone)
$________________ Home Owners' Insurance
$________________ Condominium Fees

$________________ Total Monthly Shelter Expenses

MONTHLY NON-SHELTER EXPENSES

$________________ Food
$________________ Medical
$________________ Clothing
$________________ Transportation (including auto insurance)
$________________ Home Maintenance
$________________ Life Insurance Premiums
$________________ Health Insurance Premiums
$________________ Cable T.V.
$________________ Federal and State income taxes

$________________ Other

$________________ Total Monthly Non-Shelter Expenses

MONTHLY NURSING HOME EXPENSE

$________________ Monthly Nursing Home Cost
$________________ Monthly Prescription Cost
$________________ Monthly Other Cost

$________________ Total Monthly Nursing Home Expenses

Date the nursing home is paid through: _________________

PROPERTY INFORMATION:

Real Estate:

Description & Location	Ownership H W JT	Market Value	Balance of Mortgage	Net Equity
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________

Cash Accounts:

Name of Institution	Ownership H W JT	Checking	Savings or Money Market	CD's
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________
____________________	☐ ☐ ☐	$__________	$__________	$__________

Safe Deposit Box:

Safe Deposit Box: __________ Name of Institution ______________________________

Branch ____________________ Box No.: ___________ Ownership: H ☐ W ☐ Jt ☐

Others listed on box:

Name:________________________________ Relationship:____________________

Address: ____

____

Phone:____

Investments: (Stocks, Bonds, etc. If held in street name with Broker, just list the Brokerage Account)

	Ownership H	W	JT	Value
______________________	☐	☐	☐	$________
______________________	☐	☐	☐	$________
______________________	☐	☐	☐	$________
______________________	☐	☐	☐	$________
______________________	☐	☐	☐	$________

Business Interests: (For type use "CC" for corportation, "SC" for S Corporation, "P" for Partnership, "LLC" for Limited Liability Company, and "SP" for Sole Proprietorship)

Description & Location	Ownership H	W	JT	Type CC	SC	P	LLC	SP	% Interest	Value
______________________	☐	☐	☐	☐	☐	☐	☐	☐	________	$________
______________________	☐	☐	☐	☐	☐	☐	☐	☐	________	$________

Mortgages, Notes and Other Receivables:

Owned by:	Ownership H	W	JT	Date of Note	Amount Due Now
______________________	☐	☐	☐	________	$________
______________________	☐	☐	☐	________	$________
______________________	☐	☐	☐	________	$________
______________________	☐	☐	☐	________	$________
______________________	☐	☐	☐	________	$________

Retirement Benefits (Including IRA, 401(k) and 403(b)):

	H	W	Beneficiary, if any	Present Value
______________________	☐	☐	________	$________
______________________	☐	☐	________	$________
______________________	☐	☐	________	$________
______________________	☐	☐	________	$________
______________________	☐	☐	________	$________

Miscellaneous: (List only major personal effects such as automobiles, valuable jewelry, paintings, coin collections, stamp collections, etc.)

	Ownership H	W	JT	Approximate Value (less loans)
____________________	☐	☐	☐	$__________
____________________	☐	☐	☐	$__________
____________________	☐	☐	☐	$__________
____________________	☐	☐	☐	$__________
____________________	☐	☐	☐	$__________

Life Insurance:

Company	Type (Term, W/L, etc)	Owner	Insured	Beneficiary	Alternate Death Beneficiary	Benefit	Cash Value	Policy Loans

Long Term Care Insurance:

Company	Insured	Coverage	Maximum Per Day	Lifetime Maximum	Inflation Adjusted?	Other Pertinent Terms

Estate Summary:

	H	W	JT
Real Estate	$__________	$__________	$__________
Cash Accounts	$__________	$__________	$__________
Stocks, Bonds, Mutual Funds	$__________	$__________	$__________
Business Interests	$__________	$__________	$__________
Receivables	$__________	$__________	$__________
Miscellaneous	$__________	$__________	$__________
Life Insurance Death Benefit	$__________	$__________	$__________
Retirement Benefits	$__________	$__________	$__________
Other	$__________	$__________	$__________
TOTAL	$__________	$__________	$__________

Income:

Source	H	W	JT
______________________________	$__________	$__________	$__________
______________________________	$__________	$__________	$__________
______________________________	$__________	$__________	$__________
______________________________	$__________	$__________	$__________
______________________________	$__________	$__________	$__________

Debts/Liabilities:

Type	H	W	JT
______________________	$________	$________	$________
______________________	$________	$________	$________
______________________	$________	$________	$________
______________________	$________	$________	$________
______________________	$________	$________	$________

Thank you for taking the time to fill out this form. It makes our meeting more productive. Please review the completed form to ensure information is accurate. We rely on this information in completing your long term care plan and/or estate plan.