Hill Law Group, PA
ELDER PLANNING QUESTIONNAIRE
(For a SINGLE person)

NOTE: The main person this form is about is the person who is intended to receive assistance. All questions that ask about "you" refer to the person intended to receive assistance. This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to your appointment.

Date_____ File No._____

CONTACT INFORMATION

If the "Contact person" is different from the "Client," please complete this section:

Name_____

Street Address_____

City_____ State_____ Zip_____

Home Phone No._____ Work Phone No._____

Cell Number_____ Fax Number_____

E-Mail Address_____

Which the best way to communicate with you? ___ Phone ___ Email

Is this also the person completing this form? _____yes _____no

How did you hear about this office? ___internet ___advertisement ___ friend ___Attorney ___facility employee (if a person) Name_____

CLIENT INFORMATION (Person intended to receive assistance)

Full Name_____

Street Address_____

City_____ State_____ Zip_____

Home Phone No._____ Business Phone No._____

Cell Phone No._____ Fax No._____

E-Mail Address_____

Birth Date_____ Social Security No._____

Are you a U.S. Citizen? ___Yes ___No Are you a Veteran? ___Yes ___No

If widowed, please list name of spouse and date of death _____

Was your former spouse a Veteran? ___Yes ___No

MEDICAL DATA

HEALTH

Please give a brief description of your current activity level or condition:

_____

_____

Where are you living now? _____

If you are already in a nursing home or Assisted Living Facility:

Name of Facility_____

Date Entered_____

Are you receiving Rehabilitation under Medicare? ____Yes ____ No ____ I don't know

INSURANCE

What types of health insurance do you have?

_____ Medicare ____A _____ B Date coverage began_____

_____ Medicare Part D- Prescription Drug coverage -

Provider _____

_____ HMO

Provider:_____

_____ Medicare Supplemental Insurance

Provider _____

_____ Long Term Care Insurance

Provider _____

_____ Cobra

_____ Other Health Insurance _____

PHYSICIAN

Full Name of Primary Physician_____

Street Address_____

City_____State_____Zip_____

RELATIONSHIPS

If the key people in your life are your children, please skip to "children" below.

If not, please tell us who the key people in your life are and your relationship.

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

CHILDREN (If applicable, include adult and minor children)

Name of Child 1_____ Gender:___Male ___Female

Relationship:___Natural child ___Adopted ___Stepchild

Name of Child 2_____ Gender:___Male ___Female

Relationship:___Natural child ___Adopted ___Stepchild

Name of Child 3_____ Gender:___Male ___Female

Relationship:___Natural child ___Adopted ___Stepchild

Name of Child 4_____ Gender:___Male ___Female

Relationship:___Natural child ___Adopted ___Stepchild

Name of Child 5_____ Gender:___Male ___Female

Relationship:___Natural child ___Adopted ___Stepchild

Are all of your children in good health? ___Yes ___No

Are any of your children blind? ___Yes ___No

Are any of your children disabled? ___Yes ___No

Are any of you children receiving SSI or other form of government entitlement? ___Yes ___No

If yes: How much is the child's monthly payment? $_____

Is the child receiving Medicaid or Medicare? ___Medicaid ___Medicare

Do any of your family members have any problems with:

AIDS? ___Yes ___No

Drug Addiction? ___Yes ___No

Alcoholism? ___Yes ___No

Spendthrift? ___Yes ___No

Do any of your children live with you in your home? ___Yes ___No

If yes, name of child: _____

Does a sibling live with you in your home? ___Yes ___No

If yes, name of sibling_____

ASSETS/LIABILITIES

Assets are things you own. Please be sure to list everything you own. If there is not a space for it, place it in "Other" at the end. If we provide services beyond our initial consultation we will ask you for documentation on each asset. You may want to begin organizing those documents now.
Liabilities are debts such as loans or mortgage notes.

ASSET/LIABILITY	YES/ NO	ASSET VALUE?	LIABILITY?
Example - Personal effects	*yes*	*$5,000*	*$2350.00 (loan)*
PERSONAL EFFECTS			
HOMESTEAD (TAX VALUE) Folio # _____			
AUTOMOBILE(S)			
TRADITIONAL IRA/RETIREMENT PLANS			
ROTH IRA			
PREPAID FUNERAL			
CEMETERY PLOT(S)			
CHECKING ACCOUNTS			
SAVINGS ACCOUNTS			
MONEY MARKET ACCOUNTS			

ASSET/LIABILITY	YES/ NO	ASSET VALUE?	LIABILITY?
CERTIFICATES OF DEPOSIT			
OTHER REAL ESTATE LOCATION: _____			
MINERAL RIGHTS			
BROKER/CAP ACCOUNTS			
MUTUAL FUNDS			
STOCKS			
BONDS			
ANNUITIES			
(Also see insurance page)			
LIFE INSURANCE - CASH VALUE			
(Also see insurance page)			
OTHER:			
OTHER:			
TOTAL			

LIFE INSURANCE AND/OR ANNUITIES

Life insurance can have several different values associated with it. We are particularly interested in the "Cash Value" or the value of it if you cashed it out today and the "Death Benefit" or the amount it will pay on your death. Policies often issue annual statements. If you do not have a recent one, you may need to call the life insurance company in order to obtain this information.

PLEASE MAKE AS MANY COPIES OF THIS PAGE AS YOU NEED TO COMPLETE INFORMATION ON EACH POLICY

Name of INSURANCE Company_____ Policy #_____

Street Address_____

City_____ State_____ Zip_____

Type of Policy_____ Owner_____

Insured_____ Beneficiary_____

Death Benefit: $_____ Face Value: $_____ Cash Value: $_____

Name of INSURANCE Company_____ Policy #_____

Street Address_____

City_____ State_____ Zip_____

Type of Policy_____ Owner_____

Insured_____ Beneficiary_____

Name of ANNUITY Company_____ Policy #_____

Street Address_____

City_____ State_____ Zip_____

Type of Annuity_____ Owner_____

Annuitant_____ Beneficiary_____

Purchase Amount: $_____ Cash Value: $_____

Date Purchased: _____ Maturity Date: _____ Date Annuitized: _____

Name of ANNUITY Company_____ Policy #_____

Street Address_____

City_____ State_____ Zip_____

Type of Annuity_____ Owner_____

Annuitant_____ Beneficiary_____

Purchase Amount: $_____ Cash Value: $_____

Date Purchased: _____ Maturity Date: _____ Date Annuitized: _____

CLOSED BANK/FINANCIAL ACCOUNTS

Have you closed any banking or financial accounts in the past three (3) years?

_____yes _____no

If you have please complete the following:

Account Location (Name of Institution)	Type of Account	Date Closed	Where did funds go to?

GIFTS

Have you made gifts in excess of $1,000 in any one month, to an individual or group of individuals, or to a Trust within the past 5years (60 Months)? ___Yes ___No

If yes, list below:

Recipient_____ Date_____ Amount_____

Recipient_____ Date_____ Amount_____

Recipient_____ Date_____ Amount_____

Recipient_____ Date_____ Amount_____

Recipient_____ Date_____ Amount_____

MONTHLY HEALTH INSURANCE COSTS

Medicare Part A $_____ Part B $_____ Part D $_____

Medicare Choice (HMO) Co. _____ $_____

Supplemental Insurance Co. _____ $_____

Long Term Care Co. _____ $_____

Other Health Insurance Co. _____ $_____

GROSS MONTHLY INCOME

Please list the gross, before tax, amount, including any monies taken out for health insurance, or any other reason.

(HARD INCOME)

Social Security Benefits	$_____
Pension/Retirement Benefits (Gross)	$_____
Employment	$_____
Veterans Disability Income	$_____
Annuity Income	$_____
Rental Income	$_____
TOTAL MONTHLY INCOME	$_____

(FLEXIBLE INCOME)

Income from Dividends/interest	$_____
Other_____	$_____

MONTHLY COST OF NURSING HOME OR ASSISTED LIVING

Monthly Nursing Home/ALF Cost	$_____
Monthly Prescription Medication Cost	$_____
Monthly Incontinent/ Personal Items Cost	$_____
Monthly Other Cost	$_____
TOTAL Monthly Cost	$_____

The Nursing Home has been paid through _____ (month/year)

MONTHLY HOME COSTS (Complete only if you own a home)

Electric and utilities	$_____
Homeowner's Insurance (all forms)	$_____
Condo Association Fees	$_____
Property Taxes	$_____
Mortgage	$_____
Yard Maintenance	$_____
Repairs/upkeep	$_____
TOTAL HOME COSTS	$_____

MISCELLANEOUS

Do you have any other legal issues which we should be aware of?___Yes ___No

If yes, please explain_____

_____

_____

_____

_____

CERTIFICATION

The undersigned hereby represents to Hill Law Group, PA and each of its attorneys that the information contained in this intake form is complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate or accurate. Signature of Client or Client Representative:

_____ _____

Date

The statement below is to be signed by the client or elder in need of services if other persons are attending meeting on their behalf.

I, _____, hereby authorize all attorneys and staff at HILL LAW GROUP, PA to communicate with and advise the following individual(s) on my behalf:

	Name	Relationship
1.	_____	_____
2.	_____	_____

I further declare that I understand that, once information is shared with the above named individuals, Hill Law Group, PA cannot be responsible for the acts or statements made by the above named individuals.

_____ _____

Signed Date