

ELDER LAW PLANNING SYSTEM CLIENT QUESTIONNAIRE

File Ref: _____

Name of Client/Husband	
Name of Spouse/Wife	

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to your appointment.

SECTION 1. CONTACT PERSON

CLIENT COMMUNICATIONS	
Contact Person	
Street Address	
Apt/Suite/Floor	
City, State, Zip	
Home Telephone:	
Cell Phone:	
E-mail address:	

SECTION 2. CLIENT DETAILS

2.1. NAME, ADDRESS and DOMICILE

CLIENT	SPOUSE
Name	Name
Address	Address
DOB	DOB
Social Security Number	Social Security Number
Client is U.S. citizen * <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse is U.S. citizen * <input type="checkbox"/> Yes <input type="checkbox"/> No
If not a U.S. citizen, client is citizen of	If not a U.S. citizen, client is citizen of
Domicile Details	Domicile Details
State of legal domicile is different from client's "address" state, above? * <input type="checkbox"/> Yes <input type="checkbox"/> No	State of legal domicile is different from client's "address" state, above? * <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, state of Legal Residence	If yes, state of Legal Residence

In relevant documents, Domicile should be expressed as	In relevant documents, Domicile should be expressed as
County/Political Jurisdiction	County/Political Jurisdiction
Other Details	Other Details
Has Client has been diagnosed with an illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Spouse has been diagnosed with an illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes then what?	If yes then what?
Is Client a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Spouse a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is Client receiving Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Spouse receiving Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is Client widowed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of former spouse	
Date of Death	
Was former spouse a Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, was former spouse receiving Tricare <input type="checkbox"/> Yes <input type="checkbox"/> No	

Institutionalized Spouse's Physician	Community Spouse's Physician
Do you know the name of the Institutionalized Spouse's Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you know the name of the Community Spouse's Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Name of Institutional Spouse's Physician	If yes, Name of Community Spouse's Physician
Street Address	Street Address
Suite / Office # / Address 2	Suite / Office # / Address 2
City, State, Zip	City, State, Zip

SECTION 3. INCOME & EXPENSES

3.1. MONTHLY INCOME FOR INSTITUTIONALIZED SPOUSE

INCOME for INSTITUTIONALIZED SPOUSE
Select the types of income that will be entered for Institutionalized Spouse
<input type="checkbox"/> Social Security <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> Disability <input type="checkbox"/> Annuity <input type="checkbox"/> Rental <input type="checkbox"/> Other

Monthly Income		
Net Social Security		
Medicare Part B Deduction (Select or enter a Number)		
Medicare Part D		
Pension/Retirement Benefits (Gross)		
Employment		
Disability		
Annuity		
Rental		
Other Income		
	Item	Amount
1		
2		
3		
4		
5		
6		
Total Income		

3.2. MONTHLY INCOME FOR COMMUNITY SPOUSE

INCOME for COMMUNITY SPOUSE		
Select the types of income that will be entered for Community Spouse	<input type="checkbox"/> Social Security <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare Part D <input type="checkbox"/> Pension <input type="checkbox"/> Employment <input type="checkbox"/> Disability <input type="checkbox"/> Annuity <input type="checkbox"/> Rental <input type="checkbox"/> Other	
Monthly Income		
Net Social Security		
Medicare Part B Deduction (Select or enter a Number)		
Medicare Part D		
Pension/Retirement Benefits (Gross)		
Employment		
Disability		
Annuity		
Rental		
Other Income		
	Item	Amount
1		
2		
3		
4		
5		
6		
Total Income		

3.3. MONTHLY SHELTER EXPENSES

MONTHLY SHELTER EXPENSES	
Monthly Shelter Expenses (select all that apply)	<input type="checkbox"/> Rent <input type="checkbox"/> Mortgage <input type="checkbox"/> Real Estate Taxes <input type="checkbox"/> Water <input type="checkbox"/> Sewer <input type="checkbox"/> Trash Disposal <input type="checkbox"/> Utilities <input type="checkbox"/> Homeowner's insurance premium <input type="checkbox"/> Condominium fees <input type="checkbox"/> OTHER
Rent Payments (monthly)	

MONTHLY SHELTER EXPENSES	
Mortgage Payments (monthly)	
Real Estate Taxes (monthly)	
Water	
Sewer	
Trash disposal fees	
Average Monthly Utilities Bill (Heat, Electric & Telephone) (1/12 of expenses for last 12 months)"	
Homeowner's Insurance Premium	
Condominium fees	
Other Shelter Expenses	
	Item
1	
2	
3	
4	
5	
6	
Total Shelter Expenses	

3.4. MONTHLY NON-SHELTER EXPENSES

3.5. NURSING HOME COSTS

COST OF NURSING HOME	
Monthly Costs for Nursing Home Care	
Facility Cost	
Prescription Cost	
Incontinent Cost	
Medical Insurance Cost for Institutionalized Spouse	
Are there any other Costs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If other costs:	
Other Non-shelter Expenses	
	Description of Expense
1	
2	
3	
4	
5	
6	
Total	

SECTION 4. ASSET INVENTORY AND DETAILS

4.1. NON-COUNTABLE ASSETS

Item	Husband	Wife	Joint	Liability
Home				
Automobile				
Personal Effects				
Community Spouse's Retirement Plan				

4.2. COUNTABLE ASSETS

4.2.1. CHECKING

Item	Husband	Wife	Joint	Liability

4.2.2. SAVINGS

Item	Husband	Wife	Joint	Liability

4.2.3. MONEY MARKET

Item	Husband	Wife	Joint	Liability

4.2.4. SAVINGS CERTIFICATES

Item	Husband	Wife	Joint	Liability

4.2.5. AUTOMOBILE

Item	Husband	Wife	Joint	Liability

4.2.6. OTHER REAL ESTATE

Item	Husband	Wife	Joint	Liability

4.2.7. BROKERAGE/CAP ACCTS.

Item	Husband	Wife	Joint	Liability

4.2.8. MUTUAL FUNDS

Item	Husband	Wife	Joint	Liability

4.2.9. STOCKS

Item	Husband	Wife	Joint	Liability

4.2.10. BONDS

Item	Husband	Wife	Joint	Liability

4.2.11. ANNUITIES

Item	Husband	Wife	Joint	Liability

4.2.12. CASH VALUE LIFE INS.

Item	Husband	Wife	Joint	Liability

4.2.13. TRADITIONAL IRA

Item	Husband	Wife	Joint	Liability

4.2.14. ROTH IRA

Item	Husband	Wife	Joint	Liability

4.2.15. RETIREMENT ACCOUNTS

Item	Husband	Wife	Joint	Liability

4.2.16. OTHER

Item	Husband	Wife	Joint	Liability

4.2.17. TOTAL COUNTABLE ASSETS

	Husband	Wife	Joint	Liability

SECTION 5. PRIOR TRANSACTIONS

5.1. PRIOR TRANSFERS

PRIOR GIFTS	
Has Client and/or Spouse made any gifts within last five years to an individual or to a trust?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has Client and/or Spouse ever filed a Federal Gift Tax Return?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, State details about the return	
Date of Gift amount	
Date of Gift amount	

SECTION 6. INTERESTED PARTIES

6.1. CHILDREN

Name	Contact Information	Date of Birth	Relation
			Child is child of Client Spouse Both spouses
			Child is child of Client Spouse Both spouses
			Child is child of Client Spouse Both spouses

6.2. RELATIONS and OTHER PARTIES

PRIMARY CONTACT	SECONDARY CONTACT
Name	Name
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Entity
Relation to Client	Relation to Client
Relation to Spouse	Relation to Spouse

Street Address	Street Address
Work Telephone	Work Telephone
Home Telephone	Home Telephone
Fax	Fax
Email	Email
SSN	SSN

SECTION 7. OTHER ISSUES

OTHER ISSUES	
Do you have any other legal issues which I should be aware of?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the issues below	
	Issue
1	Importance <input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
2	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
3	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
4	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry
5	<input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Inquiry

SECTION 8. REFERRAL

REFERRAL DETAILS	
By whom were you referred to this office	
Name / Firm	
Street Address	
Apt/Suite/Floor	
City, State, Zip	
Telephone	
Fax	
Email	
Referrer is	<input type="checkbox"/> Attorney <input type="checkbox"/> Financial Planner <input type="checkbox"/> Previous Client of Law Firm <input type="checkbox"/> Doctor <input type="checkbox"/> Social Worker <input type="checkbox"/> Other _____

SECTION 9. CERTIFICATION

The undersigned hereby represents to Oast & Hook, P.C. and each of its attorneys 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. 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 Client or Client Representative:

Name: Date