

FOLLOW-UP LONG-TERM CARE PLANNING QUESTIONNAIRE (MARRIED)

FILE REFERENCE: _____

FILE NO. _____

Husband: _____ Wife: _____ Date _____

Contact Person (if different from above) _____

Contact Person Address _____

Home Phone _____ Business Phone _____ E-mail _____

Thank you for taking the time to carefully complete this form. Remember, the firm's recommendations are based upon our records and the information you submit. If you have any questions, please do not hesitate to contact our office.

I. Long Term Care Costs

A. Where do you each currently live?

Husband: Own Residence Child's Home Apartment Nursing Home
 Assisted Living CCRC Other: _____

Wife: Own Residence Child's Home Apartment Nursing Home
 Assisted Living CCRC Other: _____

B. If either of you have entered a facility, please give the date you entered: _____

If applicable for husband or wife, please give the **name** of your facility _____
_____. **Date entered** _____

C. Will either of you enter a facility in the near future? When? _____

D. Are you receiving long term care in your home? Yes No
If yes, on what date did this begin? _____

E. Please list your average monthly long term care costs below:

Nursing Home Cost per Month	_____
Prescription Cost per Month	_____
Incontinent Cost per Month	_____
Other Cost per Month	_____
Home Health Aide Cost per Month	_____
TOTAL MONTHLY CARE COSTS	

F. The long term care costs are paid through the end of: _____ (month/year)

II. Living Expenses (Per Month)

Mortgage	_____	Food	_____
Rent	_____	Medical	_____
Property Taxes	_____	Clothing	_____
Water	_____	Transportation	_____
Sewer	_____	Home Maintenance	_____
Utilities	_____	Life Ins Prem.	_____
Homeowner's Ins Prem.	_____	Health Ins. Prem.	_____
Condominium Fees	_____	TV/Entertainment	_____
		Other	_____
<u>TOTALS</u>	<input type="text"/>		<input type="text"/>

III. <u>Monthly Income</u>	<u>Husband's Income</u>	<u>Wife's Income</u>
Social Security Benefits	_____	_____
Check Amount	_____	_____
Pension Benefits	_____	_____
Other Monthly Income*	_____	_____
TOTAL MONTHLY INCOME	<input type="text"/>	<input type="text"/>

*List source of "Other Monthly Income" _____

V. Transfers/Gifts Made

Please list all transfers/gifts made over \$500 to your trust, children or other beneficiaries since the date of your original Asset Protection Plan. Do not include assets that have merely been shifted from one spouse to another. This information will confirm that our records are updated. **If you fail to confirm transfers that have been made, I will be unable to assist you.**

Gifts of Cash, Stock, Bonds, Annuities, Funds:

<i>Month/Year</i>	<i>Asset Type</i>	<i>Value Transferred</i>	<i>Recipient(s)</i>

Gifts of Insurance:

<i>Month/Year</i>	<i>Company/Policy Number</i>	<i>Cash Value</i>	<i>Recipient(s)</i>

Gifts of Real Estate:

<i>Month/Year</i>	<i>Property Transferred</i>	<i>Life Estate Retained? (Yes or No)</i>	<i>Recipient(s)</i>

Automobile Transferred:

<i>Month/Year</i>	<i>Make/Model/Year</i>	<i>Value</i>	<i>Recipient</i>

VI. Spend Down Since the Date of the Asset Protection Plan

Since the time your original Asset Protection Plan was prepared.....

- A. Have you finished prepaying one or more funerals? Yes No
What amount, if any, do you have remaining to pay for this item before filing for Medicaid?
\$ _____
- B. Have you finished paying for home improvements (see below for examples)? Yes No
What amount, if any, do you have remaining to pay for these items before filing for Medicaid?
\$ _____
- C. Have you finished paying for household goods and/or personal effects (see below for examples)?
Yes No
What amount, if any, do you have remaining to pay for these items before filing for Medicaid?
\$ _____
- D. Have you finished paying down any debts, including mortgages? Yes No
If you have any debts, including mortgages, past due bills, etc., please list the amount you owe. \$ _____
- E. Have you purchased a new car? Yes No
If you intend to purchase a car before filing for Medicaid, please list the expected amount. \$ _____
- F. Do you intend to spend assets on any other expenses other than nursing costs before filing for Medicaid?
Yes No If yes, please list the expected amount. \$ _____

I have completely and accurately filled out this form to the best of my knowledge.

Signature

Some examples of Home Improvements: roof, windows, exterior paint, landscaping, carpet/flooring, air conditioning, interior paint, insulation, ceiling fans, water heater.

Some examples of Household Goods and/or Personal Effect: clothing, washer, dryer, refrigerator, stove, dishwasher, microwave, answering machine, computer, lawnmower, blinds/drapes, furniture, hearing aid, eyeglasses, dentures, medical supplies.