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

FILE REFERENCE: ______________________________

FILE NO. ______________________________

Name ______________________________ 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 currently live? ❒Own Residence ❒Child's Home ❒Apartment ❒Nursing Home ❒Assisted Living ❒ CCRC ❒ Other

If other, please explain:______________________________

B. If you have entered a facility, please give the date you entered:______________________________

C. Do you anticipate entering 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 :______________, 20__

(month/year)

II. Monthly Income

Social Security Benefits Check Amount.	______________
Pension Benefits	______________
Other Monthly Income*	______________
TOTAL MONTHLY INCOME	

*List source of "Other Monthly Income" ______________________________

III. Assets

Please list values for all accounts currently remaining in your name. Do not list any one account more than once. Please list accounts individually. **Do not list assets that have been transferred to a trust or to other individuals, e.g. your children.**

Name of Financial Institution/Brokerage Co./Insurance Company	*Type of Asset (cash, annuity, stock, bond, IRA, mutual fund, etc.) (Include cash value of life insurance.)*	*Account Value*
TOTAL		

Please include automobiles currently owned in the above listed assets.

Have you cashed in any life insurance policies? ❒Yes ❒ No
If yes, please list the company and policy no.: ____________________

Have you sold real estate since you began Asset Protection Planning? ❒Yes ❒No
When? ___________ Amount Received $____________

Have you listed real estate for sale since you began Asset Protection Planning? ❒Yes ❒No
For how much? $____________

IV. 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. 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:

Month/Year	*Asset Type*	*Value Transferred*	*Recipient(s)*

Gifts of Insurance:

Month/Year	*Company/Policy Number*	*Cash Value*	*Recipient(s)*

Gifts of Real Estate:

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

Automobile Transferred:

Month/Year	*___Make/Model/Year*	*________Value*	*_______Recipient*

V. 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. 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.