LONG TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

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CONFIDENTIAL
LONG TERM CARE PLANNING QUESTIONNAIRE

JOSEPH L. MOTTA CO., LPA
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DATE: _____

SECTION 1. NAMES AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

_____

Relationship to Client: _____

Client's Full Name: _____
(first) (middle) (last)

Client's Spouse Full Name: _____
(first) (middle) (last)

Home Address: _____

_____

	Client	**Spouse**
Telephone Numbers:	_____ (home)	_____ (home)
	_____ (cell)	_____ (cell)
Date of Birth:	_____	_____
Social Security Number:	_____	_____
US Citizen?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Veteran?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Dates of Service:	_____	_____
	_____	_____

SECTION 2. MARITAL INFORMATION

A. Date of Marriage: _____

B. Place of Marriage: _____
(city) (state or province) (country)

C. Client's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No
(still living?)

2. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No
(still living?)

D. Spouse's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No
(still living?)

2. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce
(year terminated) (how terminated)

[ ] Yes [ ] No
(still living?)

SECTION 3. CHILDREN

List all children. Copy and attach additional pages, if needed. Total number of children: _____

1. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both Is Child Married? [ ] Yes [ ] No

_____ _____
(current address) (phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

2. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both Is Child Married? [ ] Yes [ ] No

_____ _____
(current address) (phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

3. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both Is Child Married? [ ] Yes [ ] No

_____ _____
(current address) (phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

4. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both Is Child Married? [ ] Yes [ ] No

_____ _____
(current address) (phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

5. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both Is Child Married? [ ] Yes [ ] No

_____ _____
(current address) (phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

6. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both Is Child Married? [ ] Yes [ ] No

_____ _____
(current address) (phone number)

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

SECTION 4. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

_____

_____

_____

B. Spouse

_____

_____

_____

SECTION 5. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: [ ] Yes [ ] No

Spouse: [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

B. OTHER ISSUES

	Client	Spouse
Able to sign name?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to speak?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to recognize friends and family?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Cognizant of property and possessions?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to leave current residence?:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 6. PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of your primary physician.

	Client	**Spouse**
Physician's Name:	_____	_____
Specialty:	_____	_____
Address:	_____	_____
	_____	_____
Business Phone:	_____	_____

SECTION 7. LONG TERM CARE (LTC)

A. Client

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

B. Spouse

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

SECTION 8. HOSPITAL

A. Client

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

B. Spouse

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

SECTION 9. INCOME

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment is the "owner" of the income.

A. FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Social Security:	$	$	$
2.	R.R. Retirement:	$	$	$
3.	Pension:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$
6.	_____:	$	$	$

B. NON-FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Interest:	$	$	$
2.	Dividends:	$	$	$
3.	_____:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$

C. TOTALS (A thru B): **$** **$** **$**

SECTION 10. ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)
(Please provide copies of statements)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. (example)	xxx-xxxx	Savings	$ xx,xxx.xx	Client
			$	
			$	
			$	
			$	
			$	

B. BROKERAGE ACCOUNTS
(Please provide copies of statements)

Name of Investment Firm	Account No.	Account Value	How Title Held
Big Broker (example)	xxx-xxxx	$ xx,xxx.xx	Spouse
		$	
		$	
		$	
		$	

C. SECURITIES (Bonds, Marketable Securities, etc.)
(Please provide copies of statements)

Name of Company	Type of Sec.	# Shares	Cost	Current Val.	How Title Held
Acme Corp. (example)	Common Stock	xx Shares	$ x,xxx.xx	$ x,xxx.xx	Jointly
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

D. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)
(Please provide copies of statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker (example)	xxx-xxxx	Client	Spouse	Jan, 1970	$ xx,xxx.xx
					$
					$
					$
					$
					$

E. LIFE INSURANCE POLICES
(Please provide copies of policies and beneficiary designations)

Name of Company	Policy No.	Owner	Insured	Beneficiary	Face Amount	Cash Value
Premier Insurance Co. (example)	xxx-xxxx	Client	Client	Spouse	$100,000.00	
					$	$
					$	$
					$	$
					$	$

F. ANNUITY CONTRACTS
(Please provide copies of contracts and beneficiary designations)

Name of Company	Contract No.	Owner	Annuitant	Beneficiary.	Current Value
Premier Insurance Co. (example)	xxx-xxxx	Client	Client	Spouse	$100,000.00
					$
					$
					$
					$

G. REAL ESTATE (Other than Residence)
(Please provide copies of deeds and most recent tax bills)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
123 Know Way (sample)	$ xxx,xxx.xx	$ xxx,xxx.xx	$ xx,xxx.xx	Joint tenant
	$	$	$	
	$	$	$	
	$	$	$	

H. PERSONAL PROPERTY

	Market Value	How Title Held
Car 1:	$	
Car 2:	$	
Boat	$	
RV/Camper	$	
: (other: collectibles, etc.)	$	
:	$	
:	$	

I. BUSINESS INTERESTS

If Client or Spouse has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

J. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which Client or Spouse has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

_____

_____

_____

_____

_____

_____

K. MISCELLANEOUS

If Client or Spouse has any property interests not described above, please explain the nature of the interests and the estimated value of each.

_____

_____

_____

_____

SECTION 11. RESIDENCE -- OWNED

A. How is title held? _____

PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL

B. Fair Market Value: $ _____

C. Mortgage Balance: $ _____

D. Single Family Residence? [ ] Yes [ ] No

E. If the property was purchased, please provide the following:

1. Date of Purchase: _____
2. Purchase Price: $ _____

F. If the property was inherited, please provide the following:

1. Month/Year Inherited: _____

2. Value when Inherited: $_____

G. If at least one occupant of the residence is a child of the individual in need of long term care, has that child lived in the residence for at least 2 years? [ ] Yes [ ] No

1. If yes, has the child provided personal care to the parent that might have delayed the need for long term care for the parent? [ ] Yes [ ] No

2. If so, please describe the nature and duration of the care provided:

_____

_____

_____

H. Does the person needing care have any living children who are disabled? [ ] Yes [ ] No

If yes, please describe the nature of the disability:

_____

_____

I. Does the owner have a sibling who has lived in the house for at least 1 year? [ ] Yes [ ] No

If yes, does the sibling still reside in the home? [ ] Yes [ ] No

SECTION 12. RESIDENCE -- RENTED

A. Monthly Rent: $_____

B. Type of Rental: [ ] Single Family [ ] Apartment [ ] Residential Care [ ] Life Care
[ ] Senior Housing

C. Rental/Lease Agreement? [ ] Yes [ ] No

D. Is Rent Subsidized?[ ] Yes [ ] No

If so, by whom and amount? _____

SECTION 13. MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

	Client	Spouse	Joint
1. If home is owned:			
mortgage:	$	$	$
property taxes:	$	$	$
homeowner assoc. dues:	$	$	$
insurance:	$	$	$
water and sewer:	$	$	$
electricity:	$	$	$
gas:	$	$	$
telephone:	$	$	$
2. If home is rented:			
monthly rent:	$	$	$
electricity:	$	$	$
gas:	$	$	$
water and sewer:	$	$	$
_____ (other):	$	$	$

B. HEALTH INSURANCE PREMIUMS (PER MONTH)

	Client	Spouse	Joint
1. Health insurance:	$	$	$
2. Long term care insurance:	$	$	$
3. _____ (specify):	$	$	$
4. _____ (specify):	$	$	$

C. MEDICAL EXPENSES NOT COVERED BY INSURANCE (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Non-covered medications:	$	$	$
2.	_____ (specify):	$	$	$
3.	_____ (specify):	$	$	$
4.	_____ (specify):	$	$	$

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Food:	$	$	$
2.	Clothing:	$	$	$
3.	Entertainment and travel:	$	$	$
4.	Support for children:	$	$	$
5.	_____ (specify):	$	$	$
6.	_____ (specify):	$	$	$
E.	**TOTALS (A thru D):**	**$**	**$**	**$**

SECTION 14. HEALTH AND LTC INSURANCE

If Client or Spouse has Medicare Parts A, B, or D, private health or long term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
Premier Insurance Co. (example)	xxx-xxxx	Long term care	$500.00	$100.000
			$	$
			$	$
			$	$
			$	$

SECTION 15. TRANSFERS WITHIN 5 YEARS

Has Client or Spouse transferred property to someone other than his or her spouse within the past five (5) years? If so, please provide the following information and **copies of gift tax returns, if available**:

A. Client

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

B. Spouse

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

SECTION 16. TRANSFERS TO OR FROM TRUSTS

Has Client or Spouse transferred property into a Trust, or directed that property be transferred from a Trust within the past five (5) years? If so, please provide the following information:

A. Client

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

B. Spouse

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

SECTION 17. ESTATE PLANNING AND OTHER DOCUMENTS

Please indicate if you have any of the following documents, and if so provide a copy of each.

	Client	**Spouse**
Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No	[ ] Yes [ ] No
Pour-Over Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Health Care Power of Attorney (or Proxy):	[ ] Yes [ ] No	[ ] Yes [ ] No
Living Will:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 18. FUNERAL AND BURIAL CONTRACTS

Please indicate whether Client or Spouse has the listed items.

	Client	**Spouse**
Burial plot:	[ ] Yes [ ] No	[ ] Yes [ ] No
Irrevocable funeral contract:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 19. DISPOSITIVE PLANNING

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, charities.

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

Client:

A. First-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

_____

_____

B. Second-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

_____

_____

C. Any specific disposition of your residence?

_____

_____

D. Any specific gifts of special articles, such as art or jewelry?

_____

_____

E. Any specific disposition of household and personal effects?

_____

_____

F. Other information you think is important to your estate planning:

_____

_____

_____

Spouse:

A. First-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

B. Second-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

C. Any specific disposition of your residence?

D. Any specific gifts of special articles, such as art or jewelry?

E. Any specific disposition of household and personal effects?

F. Other information you think is important to your estate planning:

SECTION 20. FIDUCIARIES

Please consider who you want to handle your affairs when you cannot.

CLIENT:

A. EXECUTOR

Initial Executor

(name) (relationship)

(current address) (phone number)

Successor Executor

(name) (relationship)

(current address) (phone number)

B. TRUSTEE

Initial Trustee

(name) (relationship)

(current address) (phone number)

Successor Trustee

(name) (relationship)

(current address) (phone number)

C. GUARDIAN OF MINOR CHILDREN

Initial Guardian

(name) (relationship)

(current address) (phone number)

Successor Guardian

(name) (relationship)

(current address) (phone number)

D. AGENT UNDER POWER OF ATTORNEY

Initial Agent

(name) (relationship)

(current address) (phone number)

Successor Agent

(name) (relationship)

(current address) (phone number)

E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY

Initial Agent

(name) (relationship)

(current address) (phone number)

Successor Agent

(name) (relationship)

(current address) (phone number)

SPOUSE:

A. EXECUTOR

Initial Executor

(name) (relationship)

(current address) (phone number)

Successor Executor

(name) (relationship)

(current address) (phone number)

B. TRUSTEE

Initial Trustee

(name) (relationship)

(current address) (phone number)

Successor Trustee

(name) (relationship)

(current address) (phone number)

C. GUARDIAN OF MINOR CHILDREN

Initial Guardian

(name) (relationship)

(current address) (phone number)

Successor Guardian

(name) (relationship)

(current address) (phone number)

D. AGENT UNDER POWER OF ATTORNEY

Initial Agent

(name) (relationship)

(current address) (phone number)

Successor Agent

(name) (relationship)

(current address) (phone number)

E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY

Initial Agent

(name) (relationship)

(current address) (phone number)

Successor Agent

(name) (relationship)

(current address) (phone number)