



Timothy K. Palmer, P.C.

1530 Breezeport Way, Suite 400, Suffolk, VA 23435 Phone: (757) 484-9494 Fax: (757) 484-9191

**LONG-TERM CARE PLANNING QUESTIONNAIRE
(MARRIED)**

Date _____

Home Phone No. _____ Fax No. _____

Husband's E-mail Address _____ Wife's E-mail Address _____

Husband's Work Phone No. _____ Wife's Work Phone No. _____

Husband's Cell No. _____ Wife's Cell No. _____

This form is extremely important. Your accuracy and completeness in responding will help Timothy K. Palmer, P.C. represent you. Please bring this information with you to the appointment. PLEASE PRINT AND USE FULL LEGAL NAMES. This information may be used to prepare estate planning documents.

A. PERSONAL DATA

(Husband)	(Wife)
Full Legal Name _____	Full Legal Name _____
Home Address _____	
City _____	State _____ Zip _____
Birth Date _____	Birth Date _____
Social Security No. _____	Social Security No. _____
U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Marriage _____	

B. REFERRAL

Who referred you to this office?

Name _____

Street Address _____

City _____ State _____ Zip _____

Have you heard our radio ad? Yes No

Have you seen our newspaper ad? Yes No
 Have you visited our Website? Yes No
 Do you have any ideas for improving our Website? If so, please discuss. _____

C. CHILDREN (PLEASE PRINT FULL LEGAL NAMES SO THEY ARE LEGIBLE.)

Child's Full Legal Name	Address (including zip code)	Contact Phone Number(s)	Date of Birth

Does the Husband have any children by a previous marriage? Yes No

Does the Wife have any children by a previous marriage? Yes No

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 your children receiving SSI or other form of government entitlement? Yes No

Do any of your family members have any problems with:

Aids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Addiction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Spendthrift?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Marital Problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

D. GRANDCHILDREN (PLEASE PRINT FULL LEGAL NAMES SO THEY ARE LEGIBLE.)

Grandchild's Full Legal Name	Address (including zip code)	Date of Birth

E. LAST WILLS AND TESTAMENT INFORMATION

1. DISTRIBUTIONS TO SPOUSE AND CHILDREN

Do you wish to provide primarily for your spouse and secondarily for your children (if any)? Yes No

If you have children, do you wish to treat all of your children equally? Yes No

If not, why not? _____

After your spouse's death, at what age do you want distributions made to your children? _____
 (e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

2. DISTRIBUTIONS TO GRANDCHILDREN

If you have grandchildren, do you wish to leave a specific amount of money or a percentage of your estate to your grandchildren? Yes No

Do you wish to treat all of your grandchildren equally? Yes No

If not, why not? _____

How much do you want to leave your grandchildren? _____

At what age do you want distributions to your grandchildren? _____
 (e.g. a typical plan provides for 1/3 at age 25, 1/3 at age 30 and 1/3 at age 35 or immediate)

3. DISTRIBUTIONS TO CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? Yes No

If yes, please list:

Name of Charity	Address of Charity	Dollar Amount or Percentage

4. DISTRIBUTIONS TO OTHER BENEFICIARIES

Do you want your Will to benefit anyone other than children, grandchildren or a charity? ___ Yes ___ No

If so, please list:

Name of Beneficiary	Address of Beneficiary	Relationship	Dollar Amount or Percentage

5. EXECUTORS

Whom do you want to serve as the Executors of your Last Wills and Testaments? Please provide name, address and telephone number.

(Husband)

First Choice: ___ Spouse ___ Other _____

Second Choice: _____

Third Choice: _____

(Wife)

First Choice: ___ Spouse ___ Other _____

Second Choice: _____

Third Choice: _____

F. POWERS OF ATTORNEY

Whom do you want to serve as your Financial Agents? Please provide name, address and telephone number.

(Husband)

First Choice: ___ Spouse ___ Other _____

Second Choice: _____

Third Choice: _____

(Wife)

First Choice: ___ Spouse ___ Other _____

Second Choice: _____

Third Choice: _____

G. MEDICAL INFORMATION

1. HEALTH

Name of Ill Spouse _____

Diagnosis _____

Prognosis _____

Where is Ill Spouse Residing? _____

Is this a nursing home? ___ Yes ___ No If yes, date entered _____

Name of Well Spouse _____

Health of Well Spouse _____

Where is Well Spouse Residing? _____

Is this a nursing home? ___ Yes ___ No If yes, date entered _____

2. HEALTH INSURANCE INFORMATION

Husband's Primary Insurance

Name of Insurance Provider _____

Subscriber/Policy Number _____

Do you want to donate your eyes or organs? ___ Yes ___ No

Wife's Primary Insurance

Name of Insurance Provider _____

Subscriber/Policy Number _____

Do you want to donate your eyes or organs? ___ Yes ___ No

H. GROSS MONTHLY INCOME

	<u>Husband</u>	<u>Wife</u>
Gross Social Security Benefits	\$ _____	\$ _____
Gross Retirement Benefits	\$ _____	\$ _____
Gross VA Disability Benefit	\$ _____	\$ _____
Gross Annuity Income	\$ _____	\$ _____
Gross Rental Income	\$ _____	\$ _____
Other Monthly Income	\$ _____	\$ _____
Total Gross Monthly Income:	\$ _____	\$ _____

I. MONTHLY EXPENSES

Nursing Home Expenses	\$ _____
Assisted Living Expenses	\$ _____
In-Home Caregivers	\$ _____
Prescriptions	\$ _____
Health Insurance	\$ _____
Long-Term Care Insurance	\$ _____
Life Insurance Premiums	\$ _____

J. ASSET INFORMATION

Please list the current values of all of your assets below and provide current statements for each asset listed.

<u>LOCATION AND ACCOUNT NUMBER</u>	<u>HUSBAND</u>	<u>WIFE</u>	<u>JOINT</u>
CHECKING ACCOUNTS			
SAVINGS ACCOUNTS			

MONEY MARKET ACCOUNTS			
CDs			
AUTOMOBILES			
TAX-ASSESSED VALUE OF HOME			
TAX-ASSESSED VALUE OF OTHER REAL ESTATE			
STOCKS (NOT HELD IN A BROKERAGE ACCOUNT)			
BONDS (NOT HELD IN A BROKERAGE ACCOUNT)			
MUTUAL FUNDS (NOT HELD IN A BROKERAGE ACCOUNT)			
BROKERAGE ACCOUNTS			
NON-IRA TAX QUALIFIED RETIREMENT ACCOUNTS			
IRAs			

ANNUITIES			
PRE-PAID FUNERALS			
OTHER ASSETS			

K. LIFE INSURANCE

Company Name	Policy #/ Type of Insurance	Insured/Owner	Face/Cash Values

L. OUTSTANDING DEBT

Creditor	Type of Debt (Mortgage, Credit Card, Etc.)	Outstanding Balance

M. GIFTS

Have you made any gifts in excess of \$3,000 in any one month to an individual or group of individuals within the last 60 months? If so, please list below.

Recipient of Gift	Date of Gift	Amount of Gift

N. CERTIFICATION

The undersigned hereby represents to Timothy K. Palmer, P.C., and each of its staff 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.

Date

Signature of Client or Client Representative