

ANNE M. ZAUN, ESQ.

**CONFIDENTIAL
ELDER PLANNING QUESTIONNAIRE
(MARRIED)**

Date _____ File No. _____
Home Phone No. _____ Business Phone No. _____
Cell Phone No. _____ Fax No. _____
E-Mail Address _____

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.

A. CLIENT DATA

(Husband)

(Wife)

Full Name _____
(print name as shown on your checks)

Full Name _____
(print name as shown on your checks)

Street Address _____

City _____ State _____ Zip _____

(Husband)

(Wife)

Birth Date _____

Birth Date _____

Social Security No. _____

Social Security No. _____

U.S. Citizen? ___ Yes ___ No

U.S. Citizen? ___ Yes ___ No

Veteran? ___ Yes ___ No

Veteran? ___ Yes ___ No

If you or your spouse is a Veteran, are you receiving Tricare? ___ Yes ___ No

B. MEDICAL DATA

1. HEALTH

Name of Ill Spouse _____

Diagnosis _____

If Ill Spouse has already entered a nursing home:

Name of Nursing Home _____

Date Entered _____

Name of Well Spouse _____

Where Well Spouse Currently Resides _____

Health of Well Spouse _____

2. PHYSICIAN

Full Name of Husband's Physician _____

Street Address _____

City _____ State _____ Zip _____

Full Name of Wife's Physician _____

Street Address _____

City _____ State _____ Zip _____

3. STATE PHARMACEUTICAL PLANS

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior GOLD? Yes No

If you are a Veteran, are you currently receiving Veteran's prescription benefits? Yes No

MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (include \$88.50 Medicare Part B Deduction, if applicable)	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____	\$ _____

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Do not include interest and dividend income on this form.

D. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage	\$ _____
Real Estate Taxes	\$ _____
Water	\$ _____
Sewer	\$ _____
Utilities (Heat, Electric & Telephone)	\$ _____
(1/12th of last 12 months)	
Homeowner's insurance premium	\$ _____
Condominium fees	\$ _____
Total Monthly Housing Expenses	\$ _____

E. MONTHLY NON-SHELTER LIVING EXPENSES

Food	\$ _____
Medical	\$ _____
Clothing	\$ _____
Transportation (including auto insurance)	\$ _____
Home Maintenance	\$ _____
Life Insurance Premiums	\$ _____
Health Insurance Premiums	\$ _____
Cable TV	\$ _____
Federal and State Income Taxes	\$ _____
Other	\$ _____
Total Monthly Non-Shelter Living Expenses	\$ _____

F. GIFTS

Have you made any gifts within the last five years to an individual or to a trust? Yes No

If yes, list below:

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

If yes, please state details

G. CHILDREN (if applicable, include adult and minor children)

Name of Child _____ Gender: Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlock

Relationship to Wife: Natural child Adopted Stepchild Child born out of wedlock

Name of Child _____ Gender: ___ Male ___ Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship to Husband: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

Name of Child _____ Gender: ___ Male ___ Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship to Husband: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

Name of Child _____ Gender: ___ Male ___ Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship to Husband: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

Name of Child _____ Gender: ___ Male ___ Female

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Relationship to Husband: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

Relationship to Wife: ___ Natural child ___ Adopted ___ Stepchild ___ Child born out of wedlock

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

If yes: How much is the child's monthly payment? \$ _____

Is the child receiving Medicaid or Medicare? ___ Medicaid ___ Medicare

Do any of your family members have any problems with:

AIDS? ___ Yes ___ No

Drug Addiction? ___ Yes ___ No

Alcoholism? ___ Yes ___ No

Spendthrift? ___ Yes ___ No

Marital Difficulty? ___ Yes ___ No

Do any of your children live with you in your home? ___ Yes ___ No

If yes, name of child _____

Are you a contributor to a 529 Plan? ___ Yes ___ No

If yes, please attach a statement of the 529 account.

The undersigned hereby represents to Anne M. Zaun, Esq. that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm 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:

MEDICAID PLANNING -ADDITIONAL INFORMATION

Last Name of Client _____ File No. _____

A. ASSETS/LIABILITIES

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING				
SAVINGS				
MONEY MARKET				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ EQ. RT _____ REM. FCTR _____				
OTHER REAL ESTATE BLOCK# _____ LOT# _____ EQ. RT _____ REM. FCTR _____				
ADDITIONAL AUTOMOBILES				

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
BROKERAGE/CAP ACCOUNTS				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
TRADITIONAL IRA/RETIREMENT PLANS				
ROTH IRA				
NURSING HOME DEPOSIT				
PREPAID FUNERAL				
OTHER:				
OTHER:				
TOTALS				

What did you pay for your current home including any improvements? \$ _____

Address of any real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____

(2) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____

Name of Homeowner's Insurance Company _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____

Policy No. _____

B. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost \$ _____

Monthly Prescription Cost \$ _____

Monthly Incontinent Cost \$ _____

Monthly Medical Insurance Cost (Ill Spouse Only) \$ _____

Monthly Other Cost \$ _____

Total Monthly Cost \$ _____

The nursing home is paid through _____ (month/year).

C. LIFE INSURANCE

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____
Insured _____ Beneficiary _____
Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____
Insured _____ Beneficiary _____
Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____
Insured _____ Beneficiary _____
Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____
Insured _____ Beneficiary _____
Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____