ANNE M. ZAUN, ESQ.

CONFIDENTIAL
ELDER PLANNING QUESTIONNAIRE
(SINGLE)

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. Bring this information with you to your appointment.

A. CLIENT DATA

Full Name____
(print name as shown on your checks)

Street Address____

City____ State___________ Zip__________

Birth Date__________________________________ Social Security No.______________________________

U.S. Citizen? ___ Yes ___ No Veteran? ___ Yes ___ No

If widowed, please list name of spouse and date of death

Was your former spouse a Veteran? ___ Yes ___ No

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

B. MEDICAL DATA

1. HEALTH

Diagnosis____

If you are already in a nursing home:

Name of Nursing Home____

Date Entered____

2. PHYSICIAN

Full Name of Primary Physician____

Street Address____

City____ State__________ Zip_____________

3. 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

C. MONTHLY INCOME

Social Security Benefits (include $88.50 Medicare Part B Deduction, if applicable) $___________________

Retirement Benefits (Gross) $___________________

Veterans Disability Income $___________________

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. <u>GIFTS</u>

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 __________

Recipient________________________________ Date ____________ Amount __________

Recipient________________________________ Date ____________ Amount __________

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

If yes, please state details

____

____

____

E. <u>CHILDREN</u> (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: ___ 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: ___ 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: ___ 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: ___ 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____

Does a sibling live in your home with you? ___ Yes ___ No

If yes, name of sibling____

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

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

F. CONTACT INFORMATION

Name____

Street Address____

City_________________________ State__________ Zip__________

Home Phone Number____________________ Work Phone Number____________________

Cell Number ____________________ Fax Number____________________

E-mail Address____

G. MISCELLANEOUS

Do you have any other legal issues which I should be aware of: ___ Yes ___ No

If yes, please explain

____

____

____

____

H. REFERRAL

By Whom Were You Referred To This Office?

Name____

Street Address____

City_____________________________________ State__________ Zip____________

Home Phone Number__________________________ Work Phone Number______________

Cell Number ______________________________ E-mail Address___________________

Referral is: ___ Attorney ___ Financial Planner

___ Previous Client of Anne M. Zaun ___ Doctor

___ Social Worker ___ Other_______________________

H. CERTIFICATION

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:

X_______________________________________

MEDICAID PLANNING -ADDITIONAL INFORMATION

Last Name of Client________________________________ **File No._________________**

A. ASSETS/LIABILITIES

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING		
SAVINGS		
MONEY MARKET		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK#___________ LOT#___________ EQ. RATIO ______ REM. FCTR ________		
OTHER REAL ESTATE BLOCK#___________ LOT#___________ EQ. RATIO ______ REM. FCTR ________		
AUTOMOBILE(S)		
BROKERAGE/CAP ACCOUNTS		

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
TRADITIONAL IRA/RETIREMENT PLANS		
ROTH IRA		
NURSING HOME DEPOSIT		
PREPAID FUNERAL		
OTHER:		
OTHER:		
OTHER:		
TOTAL		

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 $___________________

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: $__________________