LONG-TERM CARE PLANNING QUESTIONNAIRE (SINGLE)

This form is extremely important. Your accuracy and completeness in responding will help Everist Tillman PLLC represent you. Please bring this completed information packet, including each of the attached schedules, to your initial consultation.

Date: _____ File No.: _____

A. CLIENT DATA

CLIENT

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone Number: _____

Business Phone Number: _____ E-mail Addr ess: _____

Date of Birth: _____ Social Security Number: _____

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

If not a Veteran, was your former spouse a Veteran? O Yes O No

If yes, please list branch and dates of service: _____

If widowed, or divorced, please provide name of former spouse(s): _____

B. MEDICAL DATA

Diagnosis: _____ Physician: _____

C. IS CLIENT CURRENTLY RECEIVING LONG-TERM CARE SERVICES?

Name of Facility/Caregiver/Provider: _____ Date of Onset of Care: _____

Address: _____

Business Phone: _____ Administrator or Contact: _____

FOR FACILITY LEVEL CARE

Date entered facility/care: _____

Medicare coverage ended/will end: _____

The facility is paid through: _____

424 94th Ave North, St Petersburg, FL 33702 • T: 727-345-5700 • email@everist-tillman.com

D. CHILDREN (if applicable, include adult and minor children, as well as any who have predeceased you)

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ______________ Cell Phone Number: ______________

Date of Birth: ______________ E-mail Address: ______________

Relationship to Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

Relationship to Co-Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ______________ Cell Phone Number: ______________

Date of Birth: ______________ E-mail Address: ______________

Relationship to Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

Relationship to Co-Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ______________ Cell Phone Number: ______________

Date of Birth: ______________ E-mail Address: ______________

Relationship to Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

Relationship to Co-Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

NAME OF CHILD: ______________________________

O Male O Female O Married O Single

Street Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone Number: ______________ Cell Phone Number: ______________

Date of Birth: ______________ E-mail Address: ______________

Relationship to Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

Relationship to Co-Client: O Natural child O Adopted O Stepchild O Child born out of wedlock O Deceased

O Please check this box and attach a separate page to list additional children.

CHILDREN (continued)

Are all of your children in good health?
O Yes O No

Are any of your children blind?
O Yes O No

Are any of your children disabled?
O Yes O No

Are any of your children receiving Supplemental Security Income or SSDI?
O Yes O No

If yes, how much is the child's monthly payment?
$ _____

Are any of your children receiving Medicaid or Medicare?
O Medicaid O Medicare

Do any of your children have any problems with:

Serious physical or mental illness?
O Yes O No

Drug Addiction?
O Yes O No

Alcoholism?
O Yes O No

Debt problems/ bankruptcy?
O Yes O No

Marital Difficulty?
O Yes O No

If you answered yes above, please list the name and reason for listing that child.

_____

_____

_____

Do any of your children owe you money, or have you made gifts to one or more of your children that you wish to treat as an advancement of their inheritance? If yes, please provide information:

_____

_____

_____

E. GRANDCHILDREN (if applicable)

NAME OF GRANDCHILD: ____________________

O Male O Female

Street Address: ____________________

City: ____________________ State: __________ Zip: __________

Phone Number: ____________________ Date of Birth: ____________________

Name(s) of Grandchild's Parent(s): ____________________

Is this grandchild a direct descendant (natural or adopted) child of your child? O Yes O No

NAME OF GRANDCHILD: ____________________

O Male O Female

Street Address: ____________________

City: ____________________ State: __________ Zip: __________

Phone Number: ____________________ Date of Birth: ____________________

Name(s) of Grandchild's Parent(s): ____________________

Is this grandchild a direct descendant (natural or adopted) child of your child? O Yes O No

NAME OF GRANDCHILD: ____________________

O Male O Female

Street Address: ____________________

City: ____________________ State: __________ Zip: __________

Phone Number: ____________________ Date of Birth: ____________________

Name(s) of Grandchild's Parent(s): ____________________

Is this grandchild a direct descendant (natural or adopted) child of your child? O Yes O No

NAME OF GRANDCHILD: ____________________

O Male O Female

Street Address: ____________________

City: ____________________ State: __________ Zip: __________

Phone Number: ____________________ Date of Birth: ____________________

Name(s) of Grandchild's Parent(s): ____________________

Is this grandchild a direct descendant (natural or adopted) child of your child? O Yes O No

O Please check this box and attach a separate page to list additional grandchildren.

GRANDCHILDREN (continued)

Are all of your grandchildren in good health?
O Yes O No

Are any of your grandchildren blind?
O Yes O No

Are any of your grandchildren disabled?
O Yes O No

Are any of your grandchildren receiving Supplemental Security Income or SSDI?
O Yes O No

If yes, how much is the grandchild's monthly payment?
$ _____

Are the grandchildren receiving Medicaid or Medicare?
O Medicaid O Medicare

Do any of your grandchildren have any problems with:

Serious physical or mental illness?
O Yes O No

Drug Addiction?
O Yes O No

Alcoholism?
O Yes O No

Debt problems/ bankruptcy?
O Yes O No

Marital Difficulty?
O Yes O No

If you answered yes above, please list the name and reason for listing that grandchild.

_____

F. GIFTS

Have you made any gifts within the last 60 months? O Yes O No

Recipient: _____ Date: _____ Amount: $_____

Recipient: _____ Date: _____ Amount: $_____

Recipient: _____ Date: _____ Amount: $_____

Recipient: _____ Date: _____ Amount: $_____

Recipient: _____ Date: _____ Amount: $_____

Recipient: _____ Date: _____ Amount: $_____

Recipient: _____ Date: _____ Amount: $_____

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

If yes, for what calendar years? _____

If yes, please provide a copy of the Gift Tax Return.

G. LONG TERM CARE INSURANCE

Do you have Long Term Care Insurance? O Yes O No

If yes, please provide a copy of the policy.

H. MISCELLANEOUS

Do you have any other legal issues I should be aware of? O Yes O No

If yes, please explain:

_____

_____

Where do you store your important papers? _____

Do you have a Safe Deposit Box? O Yes O No

If yes, please indicate the name and address of the bank: _____

Have you prepaid your burial and funeral arrangements? O Yes O No

If yes, please provide copies of your cemetery deed and funeral contract.

Is anyone in your immediate or extended family disabled (including any spouses of your children)?

O Yes O No

If yes, name and relationship of disabled family member: _____

Are there any difficult family dynamics that could impact your planning? O Yes O No

If yes, please provide information: _____

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

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

I. REFERRAL

Who referred you to our office?

Name: _____

Company Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

Have you visited our website at www.Everist-Tillman.com? O Yes O No

Do you have any ideas for improving our website? If so, please discuss: _____

J. CERTIFICATION

The undersigned hereby represents to Everist Tillman PLLC that the information contained in this questionnaire (including the attached schedules) is accurate and complete, and that the undersigned understands that the law firm will rely on this information. If the information contained herein is inaccurate or incomplete, the recommendations made by Everist Tillman PLLC may not be appropriate.

_____ _____

Signature of Client or Client Representative *Date*

FOR INTERNAL USE ONLY	
EP	
CP	
LTC	

SCHEDULE 1. FINANCIAL SUMMARY

PART ONE: INCOME

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

A. FIXED MONTHLY INCOME (GROSS)

(List only items of recurring income. Do not include interest and dividend income on this part of the form.)

	Client
1. Social Security Benefits:	$ _____
2. Retirement/Pension**:	$ _____

**Will this pension amount increase in the future? O Yes O No

	Client
3. Veterans' Disability:	$ _____
4. Annuity Income:	$ _____
5. Rental Income:	$ _____
6. Other Income:	$ _____
7. _____:	$ _____
8. _____:	$ _____
9. _____:	$ _____
10. _____:	$ _____

B. NON-FIXED MONTHLY INCOME

	Client
1. Interest:	$ _____
2. Dividends:	$ _____
3. _____:	$ _____
4. _____:	$ _____
5. _____:	$ _____
6. _____:	$ _____
7. _____:	$ _____
TOTALS (A thru B):	**$** _____

PART TWO: EXPENSES

A. MONTHLY SHELTER EXPENSES (Exact amounts are important)

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

Mortgage/Rent (include maintenance fees)	$ _____
Real Estate Taxes	$ _____
Water	$ _____
Sewer	$ _____
Utilities - Heat, Electric, and Telephone	$ _____
Homeowners Insurance Premium	$ _____
Condominium Fees	$ _____
Total Monthly Housing Expenses	**$** _____

B. MONTHLY NON-SHELTER LIVING EXPENSES (Estimates are fine)

Food	$ _____
Clothing	$ _____
Transportation (including auto insurance)	$ _____
Home Maintenance	$ _____
Life Insurance Premiums	$ _____
Cable TV	$ _____
Federal and State Income Taxes	$ _____
Entertainment and Travel	$ _____
Support for Children	$ _____
Long-Term Care Insurance Premiums	$ _____
Other	$ _____
Total Monthly Non-Shelter Living Expenses	**$** _____

PART THREE: DEFERRED EXPENSES

Real Estate Taxes	$ _____
Unpaid Medical Expenses	$ _____
Home Repairs	$ _____
Replacement of Automobile	$ _____

UNREIMBURSED RECURRING MEDICAL EXPENSES (ESTIMATES ARE FINE)

MONTHLY MEDICAL EXPENSES	CLIENT EXPENSES
Medicare (Part B)	
Medicare (Part C) or Supplemental Insurance	
Medicare (Part D) or Prescription Drug Insurance	
Prescriptions	
Nursing Home, or Assisted Living Care	
Home Health Care	
Incontinence Supplies	
Other	
Other	
Other	
Other	
Other	

PART FOUR: ASSETS AND RESOURCES

A. REAL ESTATE

(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
$ _____	$ _____	$ _____	$ _____	$ _____
$ _____	$ _____	$ _____	$ _____	$ _____
$ _____	$ _____	$ _____	$ _____	$ _____
$ _____	$ _____	$ _____	$ _____	$ _____

B. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)

(Please provide copies of most recent statements)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. *(Sample)*	xxx-xxxx	Savings	$ xx,xxx.xx	Jointly w/ son
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____
_____	_____	_____	$ _____	_____

C. SECURITIES (Bonds, Marketable Securities, etc.)

(Please provide copies of most recent statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. *(Sample)*	Common *(or Preferred)*	xx Shares	$ x,xxx.xx	$ x,xxx.xx	Sole owner
_____	_____	_____	$ _____	$ _____	_____
_____	_____	_____	$ _____	$ _____	_____
_____	_____	_____	$ _____	$ _____	_____
_____	_____	_____	$ _____	$ _____	_____
_____	_____	_____	$ _____	$ _____	_____
_____	_____	_____	$ _____	$ _____	_____

D. RETIREMENT ACCOUNTS (IRAs, Annuities, Keoghs, etc.)

(Please provide copies of most recent statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker *(Sample)*	xxx-xxxx	Client	Son/Daughter	Jan, 1970	$ xx,xxx.xx
					$
					$
					$
					$
					$
					$

E. LIFE INSURANCE (Whole Life, Term, Endowment, etc.)

(Please provide copies of most recent statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Apple Ins. Co. *(Sample)*	xxx-xxxx	Client	Son/Daughter	Jan, 1970	$ xx,xxx.xx
					$
					$
					$
					$
					$
					$

F. PERSONAL PROPERTY

	Market Value and Item	How Title Held
Home Furnishings:	$	
Cars, RVs, Boats, etc.:	$	
Cars, RVs, Boats, etc.:	$	
Cars, RVs, Boats, etc.:	$	
Jewelry , Furs, etc.:	$	
Other :	$	
Other :	$	

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

Briefly describe or give the name of any Trust in which you have an interest, or the person who is the source of the inheritance and what you expect to receive. Please provide a copy of the Will or Trust which creates the interest, if available. If not, please advise if and how we may obtain a copy.

I. BUSINESS INTERESTS

If client has an ownership in any business (whether sole proprietorship, corporation or partnership), please provide additional information regarding the nature of the interest and value of the business interest. If there are business documents (such as Buy-Sell Agreements, Stock Certificates, etc.) please provide copies.

J. MISCELLANEOUS

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

SCHEDULE 2. – SELECTING BENEFICIARIES

Please note we will spend time during our first meeting completing Schedule 2 and Schedule 3. However, you may want to review your existing documents (if any) and the following choices of beneficiaries and fiduciaries in preparation for our meeting.

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations. Are there certain items of personal property that should pass to designated individuals? Are there specific charities or individuals that you intend to leave a gift? Are some selected beneficiaries going to require a Trustee to manage their fund on their behalf?

A. First-choice beneficiaries: O Children O Other

_____

_____

B. Second-choice beneficiaries: O Children O Other

_____

_____

_____

C. Third-choice beneficiaries: O Children O Other

_____

_____

D. Any specific disposition of your residence?

_____

_____

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

_____

_____

F. Any specific disposition of other household and/or personal effects?

_____

_____

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

_____

_____

SCHEDULE 3. – SELECTING FIDUCIARIES

(Please provide names, addresses and phone numbers if chosen person is not a child or grandchild.)

POSITION **CLIENT** _____

WILL SELECTIONS:

Executor or Co-Executors _____

1st Successor(s) _____

2nd Successor(s) _____

Trustee or Co-Trustees _____

Guardian(s) for minor of disabled Children _____

FINANCIAL GENERAL POWER OF ATTORNEY:

Agent or Co-Agents _____

1st Successor(s) _____

2nd Successor(s) _____

If more than one Agent is selected, may either Agent act alone, independently of the other Agent, or must all Co-Agents act together?

___ Yes, my Co-Agents may act independently of each other.

___ No, each task must be undertaken jointly by all Co-Agents

HEALTH CARE POWER OF ATTORNEY & LIVING WILL:

Agent or Co-Agents _____

1st Successor(s) _____

2nd Successor(s) _____

If more than one Agent is selected, may either Agent act alone, independently of the other Agent, or must all Co-Agents act together?

___ Yes, my Co-Agents may act independently of each other.

___ No, each task must be undertaken jointly by all Co-Agents

RESET FIELDS SAVE SEND VIA EMAIL PRINT