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CONFIDENTIAL/PRIVILEGED
INFORMATION PROVIDED
FOR THE PURPOSE OF
SEEKING LEGAL ADVICE

CONFIDENTIAL
Elder Law Data Sheet

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.

Please bring with you any mortgage documents (especially reverse mortgages), IOUs or promissory notes, account information for any account on which you appear with the elder.

Make sure that you can provide me with copies of anything and everything you have ever received from APS, DSHS, or King County regarding allegations of abuse or neglect.

DATE: _____

NAME AND CONTACT INFORMATION

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

Home Address: _____

_____

Telephone Numbers: _____
(Best contact No.)

E-mail: _____

Relationship to Elder: _____

Do you consider yourself the client? _____

What are your goals?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Is there a current investigation of alleged elder abuse?____

By whom? _____

Please give chronology from the date of first contact to today: (attach pages as needed)

Date Contact How transmitted Allegations

SECTION 1. ELDER/SPOUSE NAME AND CONTACT INFORMATION

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

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

Home Address: _____

_____

Telephone Numbers: _____ _____
(home) (home)

_____ _____
(cell) (cell)

Dates of Birth(for each): _____ _____

Former/Maiden Names: _____ _____

US Citizen?: [ ] Yes [ ] No [ ] Yes [ ] No

Social Security Number (for each): _____

SECTION 2. 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

_____ _____
(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

_____ _____
(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

_____ _____
(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 3. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Elder

_____

_____

_____

B. Spouse

_____

_____

_____

SECTION 4. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Elder: [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

B. OTHER ISSUES

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

SECTION 5. PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of the Elder's primary physician.

	Client	Spouse
Physician's Name:	_____	_____
Specialty:	_____	_____

Address: _____ _____

_____ _____

Business Phone: _____ _____

SECTION 6. RESIDENCE -- OWNED

A. Owners: _____

B. How is title held? _____

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

C. Fair Market Value: $ _____

D. Mortgage Balance: $ _____

Is it a Reverse Mortgage [ ] Yes [ ] No

Basic Mortgage Terms: _____

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

F. If the property is rental property, please provide the following:

1. Number of units: _____
2. Currently being rented? [ ] Yes [ ] No
3. Are tenants under lease? [ ] Yes [ ] No

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

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

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

1. Month/Year Inherited: _____
2. Value when Inherited: $ _____

I. If improvements have been made to the property, please detail the value and nature of them:

_____

_____

_____

J. Have the owners used the capital gains tax exclusion? [ ] Yes [ ] No

K. 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:

_____

_____

_____

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

If yes, please describe the nature of the disability:

_____

_____

M. 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 7. 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 8. 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: _____

SECTION 9. HOSPITAL

A. Elder

Currently in Hospital? [ ] Yes [ ] No

Last admission date: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No

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

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 vehicle is the "owner" of the income.

	Elder	Spouse
Salary:	$_____	$_____
Pension:	$_____	$_____
Annuities:	$_____	$_____
Social Security:	$_____	$_____
SSI:	$_____	$_____
Investment Income	$_____	$_____
Interest Income:	$_____	$_____
Other:	$_____	$_____
Total monthly	$_____	$_____

Is there any income not accounted for above that comes in periodically?
Please describe:

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
				Jointly w/ son
			$	
			$	
			$	
			$	
			$	

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

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
			$	$	
(					
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

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

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
					$
(sample)					
					$

_____ _____ _____ _____ _____ $ _____

D. REAL ESTATE
(Please provide copies of deeds and most recent tax bills)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
	$			
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	

E. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$	
Cars, RVs, Boats, etc.:	$	
Jewels, Furs, etc.:	$	
_____: (other: collectibles, etc.)	$	
_____:	$	
_____:	$	

F. BUSINESS INTERESTS

If the person needing long-term care 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.

_____

_____

_____

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

Briefly describe or give the name of the Trust in which the person needing long-term care 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.

H. MISCELLANEOUS

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each.

SECTION 11. PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

A. Responsible for Client:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

3. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

SECTION 13. UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

_____

_____

_____

SECTION 14. MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

	Client	Spouse	Joint
1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*:	$	$	$
2. If home is rented, total rent, including maint. fees, if any:	$	$	$

* Is the senior citizen real property tax exemption being used? [ ] Yes [ ] No
Is the veterans real property tax exemption being used? [ ] Yes [ ] No

B. INSURANCE PREMIUMS (PER MONTH)

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

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

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

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

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

SECTION 15. HEALTH AND LTC INSURANCE

If the person needing care 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
			$	$
			$	$
			$	$
			$	$
			$	$

SECTION 16 PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	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
_____: (specify)	[ ] Yes [ ] No	[ ] Yes [ ] No
_____: (specify)	[ ] Yes [ ] No	[ ] Yes [ ] No
_____: (specify)	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 17. TRANSFERS WITHIN 60 MONTHS

Has the person needing care transferred property to someone other than his or her spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**:

A. Elder

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

SECTION 18. TRANSFERS TO OR FROM TRUSTS

Has the person needing care transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

A. Elder

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

PLEASE TELL US IF THE SPOUSE OF THE PERSON REQUIRING CARE HAS TRANSFERRED