

ZACHARIA & BROWN

Elder Law Attorneys

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ELDER LAW PLANNING QUESTIONNAIRE - SINGLE
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Primary Contact Information

Name: _____ Initial Contact Date: _____
Address: _____ Meeting Date _____
Tel: (H) _____ Referred by: _____
(W) _____
Fax: _____
Email: _____

PART A. PERSONAL INFORMATION

Name: _____ US Citizen _____
Address: _____ DOB or Age _____
_____ SSN _____
Tel: _____
Relationship to Contact _____

Diagnosis: _____
Prognosis: _____
Course of treatment: _____

If already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis:

Name of Nursing Home: _____ Date entered: _____
Address: _____ Tel: _____
Type: ___ Nursing Home ___ Assisted Living ___ Personal Care ___ Continuing Care ___ None yet

Health Insurance Plan: _____ Medicare Supplement Type: _____
Long Term Care Insurance? _____

PART B. CHILDREN

CHILDREN'S NAMES	ADDRESS w/ ZIP CODE	TELEPHONE	BIRTHDATE

Is any child disabled? _____ Does any child live at home? _____ Provide Care? _____

PART C. MONTHLY INCOME

Monthly Income

Gross Salary or Wages \$ _____
Social Security Benefits (including Medicare Part B premiums) \$ _____
Retirement Benefits (401k – IRA) \$ _____
Pension* \$ _____
Interest \$ _____
Dividends \$ _____
Other \$ _____

TOTAL INCOME \$ _____

* If there is a pension, please list the gross pension amount and the name of the company or governmental entity paying the pension.

Gross Amount \$ _____ \$ _____ \$ _____

Provided by: _____

PART D. ASSETS

Please insert the approximate value of each asset and liability in the appropriate space.

Real Estate

Home?	Address	City	State	Assessed Value	Names on Deed
Y / N	_____	_____	_____	\$ _____	_____
Y / N	_____	_____	_____	\$ _____	_____
Y / N	_____	_____	_____	\$ _____	_____

Financial Assets

No.	Type	Where Held	Value	Value Date	Name(s) on Account
01	_____	_____	_____	_____	_____
02	_____	_____	_____	_____	_____
03	_____	_____	_____	_____	_____
04	_____	_____	_____	_____	_____
05	_____	_____	_____	_____	_____
06	_____	_____	_____	_____	_____
07	_____	_____	_____	_____	_____
08	_____	_____	_____	_____	_____
09	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____
11	_____	_____	_____	_____	_____
12	_____	_____	_____	_____	_____
13	_____	_____	_____	_____	_____
14	_____	_____	_____	_____	_____
15	_____	_____	_____	_____	_____
16	_____	_____	_____	_____	_____
17	_____	_____	_____	_____	_____
18	_____	_____	_____	_____	_____
19	_____	_____	_____	_____	_____
20	_____	_____	_____	_____	_____
21	_____	_____	_____	_____	_____
22	_____	_____	_____	_____	_____
23	_____	_____	_____	_____	_____
24	_____	_____	_____	_____	_____
25	_____	_____	_____	_____	_____

Types:
 Checking - Savings - Money Market - Certificate of Deposit - Savings Bonds - Other Bonds - Mutual Funds - Stocks - Annuities
 IRA - 401(k) - Boats - Trailers - Automobiles - Income Producing Property - PrePaid Funeral - Prepaid Burial - Burial Plots

Life Insurance

Company	Owner	Insured	Face Value	Cash Value	Death Benefit	Beneficiaries
_____	_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	\$ _____	_____

IT IS VERY IMPORTANT TO KNOW THE CASH VALUE OF YOUR LIFE INSURANCE POLICY. TO OBTAIN THE CASH VLAUE OF THE POLICY, PLEASE CALL YOUR INSURANCE AGENT, OR CALL THE INSURANCE COMPANY DIRECTLY.

PART F. MONTHLY EXPENSES

Mortgage:	\$ _____
Rent	\$ _____
Taxes	\$ _____
Water	\$ _____
Sewer	\$ _____
Gas	\$ _____
Electric	\$ _____
Telephone	\$ _____
Homeowner's Insurance	\$ _____
Condominium Fees	\$ _____
TOTAL	\$ _____

PART G. MONTHLY NON-SHELTER LIVING EXPENSES

Food	\$ _____
Medical	\$ _____
Clothing	\$ _____
Transportation	\$ _____
Home Maintenance	\$ _____
Life Insurance Premiums	\$ _____
Health Insurance Premiums	\$ _____
Cable TV	\$ _____
Other	\$ _____
Other	\$ _____
Other	\$ _____
Monthly Total	\$ _____

PART H. MONTHLY COST OF NURSING HOME, IF APPLICABLE

Cost per Month	\$ _____
Prescription costs per month	\$ _____
Incontinent per month	\$ _____
Other per month	\$ _____
Monthly Total	\$ _____

PART I. GIFTS

(Gifts made in excess of \$1,000 per year to someone other than your spouse within the past 36 months.)

Recipient: _____ Date Made: _____ Amount: \$ _____
Recipient: _____ Date Made: _____ Amount: \$ _____
Recipient: _____ Date Made: _____ Amount: \$ _____

PART J. ESTATE PLAN

Please provide copies of these documents

- | | Yes / No |
|--|----------|
| 1. Is there a Will? | _____ |
| 2. Is there a Trust? | _____ |
| 3. Is there Power of Attorney? | _____ |
| 4. Is there a Health Care Power of Attorney? | _____ |
| 5. Is there a Living Will? | _____ |

MISCELLANEOUS

1. Name of Accountant: _____ Tel: _____
2. Name of Financial Advisor: _____ Tel: _____

Information provided by you is **very important**. It is needed to assist in making appropriate recommendations to you. Thus, it needs to be as complete and accurate as possible.

Questionnaire Signature

Date: _____
Signature _____