MORGAN AND DiSALVO, P.C.
attorneys at law

RICHARD M. MORGAN, Esq.
rmm@morgandisalvo.com

LORAINE M. DiSALVO, Esq.
ldisalvo@morgandisalvo.com

OF COUNSEL
DIANE B. WEINBERG, Esq.
dweinberg@morgandisalvo.com

ELDER LAW INITIAL CONSULTATION QUESTIONNAIRE – SINGLE INDIVIDUAL

Thank you for taking time to complete the attached questionnaire. Your accuracy and completeness in responding will help me best represent you. Please bring this questionnaire and supporting documentation with you to the appointment.

1. CONTACT INFORMATION

You:

Name:_____

Address: _____

_____

Telephone Number(s): home: _____ cell: _____ work: _____

E-Mail: _____

Relationship to Client:_____

Name of Potential Client: _____

Primary residence:_____

_____

Current address, if different Please identify type of facility, if applicable:_____

_____

_____

Telephone Number(s): home: _____ cell: _____ work: _____

E-Mail: _____

What is your primary concern?

_____ Eligibility for public benefits
_____ Medicaid Planning / Paying for Nursing Home Care
_____ Eligibility for VA or Military benefits.
_____ Guardianship or Conservatorship
_____ Finding appropriate housing
_____ Estate Planning (wills, trusts)
_____ Advance Directives (medical, financial powers of attorney)
_____ Other:

Who can we thank for the referral to our law firm? _____

2. DOCUMENTS

Please bring copies of any documents you consulted to answer any question to the initial meeting. In addition, please bring a copy of the following:

- ☐ Wills and any codicils
- ☐ Trust agreements
- ☐ Health Care Power of Attorney
- ☐ Financial Power of Attorney
- ☐ Copy of any discharge papers, including the DD214 (veterans only)

3. PERSONAL DATA – Please complete both columns.

	You	**Your spouse, *only if you are widowed***
Full Name		
Birth Date		
Social Security No.		
Deceased? (date):		
Religion		
Employer		
U.S. Citizen?	Yes ☐ No ☐	Yes ☐ No ☐
Veteran?	Yes ☐ No ☐	Yes ☐ No ☐
Provide dates of service, rank achieved, and whether any benefits are/were received:		
Railroad Employee?	Yes ☐ No ☐	Yes ☐ No ☐
Provide dates of service, rank achieved, and whether any benefits are/were received:		
Union Member?	Yes ☐ No ☐	Yes ☐ No ☐
Provide dates of service, rank achieved, and whether any benefits are/were received:		

4. FAMILY

Do you have any family members or others who depend on you for support? Explain.

_____

_____

Does any family member have any significant mental or physical disability? Explain.

_____

_____

Children. Please identify any children who have predeceased you.

(1) _____ DOB: _____

Married? ☐ Divorced? ☐ Widowed? ☐ Children? ☐ Disabled spouse or children? ☐

(2) _____ DOB: _____

Married? ☐ Divorced? ☐ Widowed? ☐ Children? ☐ Disabled spouse or children? ☐

(3) _____ DOB: _____

Married? ☐ Divorced? ☐ Widowed? ☐ Children? ☐ Disabled spouse or children? ☐

(4) _____ DOB: _____

Married? ☐ Divorced? ☐ Widowed? ☐ Children? ☐ Disabled spouse or children? ☐

5. MEDICAL DATA

a. Medical Conditions

Relevant Diagnosis: _____

b. Health Insurance

Medicare Part A?	Yes ☐ No ☐
Medicare Part B?	Yes ☐ No ☐
Medicare Part D?	Yes ☐ No ☐

		Please provide insurance company & policy no.
Medigap/Medicare Supplemental Ins.?	Yes ☐ No ☐	
Medicare Advantage?	Yes ☐ No ☐	
Other Employer Benefit?	Yes ☐ No ☐	
Medicaid	Yes ☐ No ☐	**Type?**

6. MONTHLY INCOME (Pre-Tax)

Social Security Benefits (before Medicare Part B Deduction)	$
Pension Benefits (Gross – before any deductions)	$
Other Employer Retirement Benefit	$
Annuity Income	$
Rental Income	$
Salary or other wages, including self-Employment Income (Gross – before any deductions)	$
VA Disability Benefit	$
Other Income	$
TOTAL	$

7. AVERAGE MONTHLY EXPENSES

HOUSING		AUTOMOBILE	
Rent/Mortgage	$	Loan	$
Property Taxes	$	Insurance	$
Insurance	$	Gas/Oil	$
Telephone	$		
Cable TV / Internet	$	DEBTS	
Electric/Gas	$	Credit Card	$
Water/Sewer	$	Other	$
HOA	$		
		MISCELLANIOUS	
MEDICAL		Gifts / Tithing	$
Doctor/Dentist	$	Food	$
Home Health Care	$	Other	$
Insurance	$		
Prescriptions	$		

8. RESOURCES

Asset	Ownership: Identify if [J]ointly owned and with whom	Description, including value
Residence		Address: Mortgage Balance: $ Tax Assessed Value: $
Other Real Estate		Address: Mortgage Balance: $ Tax Assessed Value: $
Checking Account		Bank Name: Balance: $
Savings Account		Bank Name: Balance: $
Automobile 1		Year, Make, Model: Amount Owed:
Automobile 2		Year, Make, Model: Amount Owed:
Money Market Account		Bank Name: Balance: $
Certificates of Deposit		Bank Name: Value: $ Maturity Date:
Mutual Funds		Bank Name: Value: $
Annuities		Company Name: Value: Beneficiary (if any):
IRA 1 / Retirement Account		Company Name: Value: $ Beneficiary:
IRA 2 / Retirement Account		Company Name: Value: $ Beneficiary:

Bonds		Company: Value: $
Stocks, Mutual Funds, Other Investments		Company: Shares: Purchase Value: $
Loans, Promissory Notes, Collections		Borrower / Debtor: Amount of loan: $ Balance: $
Burial Funds, Contracts		Name of plan, funeral home, cemetery: Balance owed, if any: $
Nursing Home Prepayments		Facility: Amount of prepayment: $
Safe Deposit Box		Bank and location: Items contained therein:
Trusts		
Other		

9. BUSINESS OWNERSHIP

Do you own a business?_____Business Name_____

Street _____City _____State _____Zip _____

Incorporation Status:_____ Names of other owners:_____

10. LIFE INSURANCE

Company	**Death Benefit**	**Face Value**	**Cash Value, if any**	**Insured**	**Owner**
	$	**$**	**$**		
	$	**$**	**$**		
	$	**$**	**$**		

11. GIFTS (e.g., money, car, school tuition, etc.)
Have you made any transfers or gifts to a person (including a child/grandchild), charity or trust in the past five (5) years? Yes ☐ No ☐

If yes, please state to whom/what the gift was made, the date and amount as to each: _____

_____

_____

_____

12. HOUSING NEEDS

a. **Activities of Daily Living (ADLs)**

Please indicate your ability to perform the following tasks:

Activity	No help needed	Needs some help	Unable to perform
Bathing			
Dressing			
Grooming			
Toileting			
Feeding self			
Transferring from bed to chair			
Walking			
Using the telephone			
Shopping			
Driving			
Managing money			
Cleaning house			
Taking medications			
Preparing meals			

b. **Physical Limitations**

Please state whether you have any limitations in the following areas:

_____Hearing	_____Speech	_____Vision
_____Walking	_____Memory	_____Balance
_____Bladder Control	_____Bowel Control	_____Eating/Digestion
_____Orientation	_____Pain	_____Other: _____

c. **What problems, if any, do you have with your current living arrangement?**

_____Unsafe neighborhood	_____No friends, family nearby
_____Expensive to maintain	_____Cannot access rooms in the house
_____Cannot see well inside	_____Lack of privacy

_____Cannot access things inside the house, like light switches, cabinets and drawers

13. LEGAL

		Date Made	Location of Original
Last Will and Testament	Yes ☐ No ☐		
Durable Power of Attorney	Yes ☐ No ☐		
Living Will/Health Care Proxy	Yes ☐ No ☐		
Living Trust	Yes ☐ No ☐		

I am the legally appointed guardian of:_____

I have been appointed an agent under a power of attorney for:_____

I am currently serving as executor or administrator of an estate:_____

I am involved in a lawsuit (explain):_____

_____

14. OTHER PROFESSIONALS: Name/Telephone Number

CPA / Tax preparer _____

Financial Advisor _____

Insurance Advisor _____

Attorney _____

15. Please provide any other information you believe is relevant.