



ELDER LAW INITIAL CONSULTATION QUESTIONNAIRE – MARRIED COUPLE

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(s): _____

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.

	Spouse 1 -	Spouse 2 -
Full Name		
Birth Date		
Social Security No.		
Deceased? (date):		
Religion		
Employer		
U.S. Citizen?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Veteran?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provide dates of service, rank achieved, and whether any benefits are/were received:		
Railroad Employee?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Provide dates of service, rank achieved, and whether any benefits are/were received:		
Union Member?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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

Spouse 1:

Relevant Diagnosis: _____

Spouse 2:

Relevant Diagnosis: _____

b. Health Insurance

	Spouse 1	Spouse 2
Medicare Part A?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicare Part B?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Medicare Part D?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

	Spouse 1	Spouse 2	Please provide insurance company & policy no.
Medigap/Medicare Supplemental Ins.?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Medicare Advantage?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other Employer Benefit?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Medicaid	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Type?

6. MONTHLY INCOME (Pre-Tax)

	Spouse 1	Spouse 2
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: Spouse 1 (S1) Spouse 2 (S2) or Joint	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		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 (S1 or S2):

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

	Spouse 1	Spouse 2	Date Made	Location of Original
Last Will and Testament	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Durable Power of Attorney	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Living Will/Health Care Proxy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Living Trust	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		

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.