FITZWATER LAW

Estate Planning | Trusts | Special Needs | Elder Law | Probate

info@fitzwaterlaw.com · phone 503.786.8191
6400 SE Lake Road, Suite 440, Portland, OR 97222

Long Term Care Planning Questionnaire

Your Name(s): __________ Date: __________

Address: __________

Billing Address (if different from above): __________

Phone: __________ Birth Date(s): __________

Last 4 digits of Social Security Number(s): __________

Email(s): __________

Would you like to receive our electronic newsletters?

- ☐ *Elder Law Newsletter*
- ☐ *Estate Planning Newsletter*
- ☐ *Special Needs Newsletter*

Referred by:

- ☐ Attorney — Name: __________
- ☐ Accountant — Name: __________
- ☐ Financial Planner — Name: __________
- ☐ Senior Program — Program Name: __________
- ☐ Medical Provider — Name: __________
- ☐ Friend/Family — Name: __________
- ☐ Website
- ☐ Yellow Pages
- ☐ Radio/TV
- ☐ Other — Please Explain: __________

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PERSON NEEDING CARE:

Full Name: ______________________________

Date of Birth: ______________ Social Security Number: ______________

Spouse / Partner: ______________ Spouse / Partner Date of Birth: ______________

Where does the person currently reside? ☐ *at Home* ☐ *In a Facility*

Name of Facility: ______________________________

Is the person needing care a veteran? ☐ *yes* ☐ *no*

Type of Facility? ☐ *Foster Home* ☐ *Assisted Living* ☐ *Don't Know* ☐ *Memory Care* ☐ *Nursing Home*

Address: ______________________________

Phone: ______________ County: ______________

FAMILY INFORMATION:

Name	Address	Date of Birth	Relationship

Does the person needing care have any of the following:

Will: ☐ *yes* ☐ *no* Copy Provided: ☐ *yes* ☐ *no*

Trust: ☐ *yes* ☐ *no* Copy Provided: ☐ *yes* ☐ *no*

Power of Attorney: ☐ *yes* ☐ *no* Copy Provided: ☐ *yes* ☐ *no*

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For Income Information: our office needs documents to prove the amounts of gross income provided below (e.g. Social Security Award Letter, Pension Stubs, Check Stubs, etc.).

Person Needing Care Income Information

Source	Gross Amount	List Deductions and Amounts	Net Amount	Document Provided
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no

Person Needing Care Spouse/Partner Income Information

Source	Gross Amount	List Deductions and Amounts	Net Amount	Document Provided
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no

Person Needing Care Health Insurance Information

Provider *(Medicare / Blue Cross / Kaiser)*	Mthly Premium	How Paid	Source of Payment	Document Provided
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no

Person Needing Care Spouse/Partner Health Insurance Information

Provider *(Medicare / Blue Cross / Kaiser)*	Mthly Premium	How Paid	Source of Payment	Document Provided
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no

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Please list all assets and resources owned by the person needing care and/or spouse. Indicate who owns which asset, or if it is jointly owned.

Real Property Information

Address & Owner	Real Market Value (RMV)	Property Tax Per Year	Home Insurance Per Year	Mortgage Payment

Bank Account Information

Name of Bank & Acct. Owner	Account Type (checking, saving, cd)	Account No. (last 4 digits)	Statement Date (mm/dd/yyyy)	Account Value

Other Securities (Non-Retirement): please list any investment accounts, bonds, mutual funds, stocks, or other securities that you own and that have not already been included in the accounts listed above:

Institution & Acct. Owner	Account Type (checking, saving, cd)	Account No. (last 4 digits)	Statement Date (mm/dd/yyyy)	Account Value

Life Insurance/Annuities:

Company & Policy Owner	Cash Value	Beneficiary	Statement Date	Policy Type

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Vehicles

Owner	Make	Model	Year	Value

INFORMATION ABOUT MONTHLY EXPENSES:

Rent or Mortgage payments (if any): ______________ *per month*

Property Taxes: __________ *annually or* ______________ *per month*

Homeowners or Renter's Insurance: ______________ *per month*

Condo or Maintenance Fees (if any): ______________ *per month*

Which utilities does the person needing care / spouse pay: ☐ *Water* ☐ *Electricity* ☐ *Sewer* ☐ *Heat* ☐ *Gas* ☐ *Trash*

Other significant assets or expenses: ______________

STATUS OF MEDICAID APPLICATION:

Have you applied for Medicaid yet? ☐ *yes* ☐ *no*

What was the date you requested an application? ______________

Date that the applicant began paying for care (either in home or in a facility): ______________

Name of current Medicaid Caseworker? ______________ Phone? ______________

Date by which you want Medicaid to start paying for care: ______________