This form is extremely important. Your accuracy and completeness in responding will help us best represent you. Please mail this form back to us or bring it with you to our appointment.

LONG TERM CARE ASSET AND INCOME PRESERVATION PLANNING

Name of Person filling out form: __________________ Relationship to Applicant: _____________

Who referred you to our firm: ____

PERSONAL DATA

Long Term Care Applicant:

Full Name __________________________________ Known by Other Names? ________________________

Address ____________________________________ City/Town_________________State:______Zip Code_____

Phone: ____________________________________

Name & Address of Nursing Home: ____

Date admitted to Nursing Home: ____________ Diagnosis _________________________________

Current mental condition: ____

Date of Birth ____________ Age _____ US Citizen? ______ If not, immigration status? __________

Social Security Number ____

Do you have any pets? If so, how many and what kind? _______________________________________

Marital status: _______________

Do you have a pre-nuptial agreement? ____ post-nuptial agreement? ___

Previous Marriages (details) ____
____

Any support or other obligations arising from previous marriage? ________________________________

Veteran? ______ Branch of service? _______________ Which years did you serve? ____________

Retired? _______ (Previous) Occupation: ____

Applicant's Spouse:

Full Name ________________________________ Known by any Other Names ______________________________

Address ____________________________________ City/Town_________________State:______Zip Code_____

Phone: Residence __________________________ Work: __________________ Cell: __________________

Date of Birth _______________________ Age: ______ US Citizen? ________________________________

Social Security Number ____

Date of Marriage _________________

Previous Marriages (details) ____

Any support or other obligations arising from previous marriage? ________________________________

Retired? _______ (Previous) Occupation: ____

State of Health ___________________________ Insurable? __________________________

Veteran? ______ Branch of service? _______________ Which years did you serve? ____________

APPLICANT'S CHILDREN (If applicable)

(Please list all children including any children adopted, from previous marriage, or predeceased. If you need more space, use back of the form.)

1. Child's Name ________________________ Present Age ______ Occupation ____________________
   Address ______________________________City/Town_______________State_______Zip Code______
   Home Phone: ___________________ Cell:__________________ Business:_______________________
   E-Mail: ______________________________
   Child's Spouse's Name ________________________ Occupation __________________________
   Child's Children______________________________ Age _________________
   ______________________________ Age _________________
   Comments ____

2. Child's Name ________________________ Present Age ______ Occupation ____________________
   Address ______________________________City/Town_______________State_______Zip Code______
   Home Phone: ___________________ Cell:__________________ Business:_______________________
   E-Mail: ______________________________
   Child's Spouse's Name ________________________ Occupation __________________________
   Child's Children______________________________ Age _________________
   ______________________________ Age _________________
   Comments ____

3. Child's Name ________________________ Present Age ______ Occupation ____________________
   Address ______________________________City/Town_______________State_______Zip Code______
   Home Phone: ___________________ Cell:__________________ Business:_______________________
   E-Mail: ______________________________
   Child's Spouse's Name ________________________ Occupation __________________________
   Child's Children______________________________ Age _________________
   ______________________________ Age _________________
   Comments ____

4. Child's Name ________________________ Present Age ______ Occupation ____________________
   Address ______________________________City/Town_______________State_______Zip Code_____
   Home Phone: ___________________ Cell:__________________ Business:_______________________
   E-Mail: ______________________________
   Child's Spouse's Name ________________________ Occupation __________________________
   Child's Children______________________________ Age _________________
   ______________________________ Age _________________
   Comments ____

Are any children adopted? ____

Are any children from a previous marriage? ____

Are any children handicapped or in poor health?____

Are any children receiving SSI or any other form of government entitlement? ___________________________

Have any of Applicant's children died leaving children of their own? ______________________________________

Does the Applicant or Applicant's spouse have any stepchildren from a previous marriage whom they wish to include in their estate plan? ____________________

Are their parents living?
Applicant's father ____ Applicant's mother _____ Spouse's Father ____ Spouse's Mother ____

Do they have living siblings? How many? Applicant: ____________ Spouse: _______________

Other relatives or friends of Applicant and Spouse who would be immediate beneficiaries or ultimate beneficiaries if Applicant, Spouse, all children, grandchildren, and parents are deceased (use the back of this sheet if you need more space).

Name _________________________ _________________________ _________________________
Residence _____________________ _________________________ _________________________
_____________________________ _________________________ _________________________
Age__________________________ _________________________ _________________________
Relation_______________________ _________________________ _________________________

Charities as immediate beneficiaries or ultimate beneficiaries if all individual beneficiaries are deceased.

Name_________________________ _________________________ _________________________
Address_______________________ _________________________ _________________________
_____________________________ _________________________ _________________________
Purpose_______________________ _________________________ _________________________

ESTATE PLANNING PROVISIONS

Does anyone to whom Applicant may be leaving part of his/her estate require any help or protection in managing money or property? If yes, details:
____
____

To the Applicant:

FIDUCIARIES:
Please consider which person(s) you would like to administer your estate and care for your minor or disabled children. If you are listing anyone not listed as a family member above, please give us his or her address and phone number.

	YOU	YOUR SPOUSE
EXECUTOR OF YOUR WILL:		
Primary:	___________________	_______________________
Successor:	___________________	_______________________
TRUSTEE(S) OF YOUR TRUST(S):		
Primary:	___________________	_______________________
Successor:	___________________	_______________________

DISPOSITION OF YOUR ESTATE

What are your general desires as to the disposition of your estate? Indicate any specific gifts of cash or items you wish to make:

Specific Gifts	Name of Recipient	Relationship and Address
______________________	______________________	______________________________
______________________	______________________	______________________________
______________________	______________________	______________________________
______________________	______________________	______________________________
______________________	______________________	______________________________

POWER OF ATTORNEY:

Have you ever given anyone a power of attorney? _________________
If so, to whom and when? ____
Is it still in effect? ____

HEALTH CARE PROXY:

Have you ever given anyone the power to make health care decisions for you? _________________________
If so, to whom and when? ____
Is it still in effect? ____

Please consider which person(s) you would like to manage your finances and health care in the event that you are incapacitated. If you are listing anyone not listed as a family member above, please give us his or her address and phone number.

	YOU	YOUR SPOUSE
POWER OF ATTORNEY:		
Primary:	_________________	_____________________
Successor:	_________________	_____________________
HEALTH CARE PROXY:		
Primary:	_________________	_____________________
Successor:	_________________	_____________________

LIVING WILL:
Do you have a living will in which you express your wishes as to end-of-life decisions? _________________

If not, are you interested in addressing these issues? ____

MEDICAID PLANNING PROVISIONS
GENERAL QUESTIONS

Has the Applicant or Applicant's spouse ever applied for or received medical assistance? ________________

If yes, where and when? ____

Is the Applicant or Applicant's spouse requesting medical assistance because of an injury, disease, or disability that was caused by someone else or that may be covered by insurance other than health insurance? ____________

If yes, is any lawsuit, worker's compensation, or insurance claim pending? _____________________

HEALTH INSURANCE:

Please list details about any health insurance available:

Applicant:

	Claim Number	Amount of Premium	Who Pays?	Effective Date
Medicare: A? B?				
Medicare supplement:___________				
Insurance from employer				
Other: _______________				

Applicant's Spouse:

	Claim Number	Amount of Premium	Who Pays?	Effective Date
Medicare: A? B?				
Medicare supplement:___________				
Insurance from employer				
Other: ___________				

Do you or your spouse have Long Term Care Insurance? __________
(if yes, please bring a copy of your policy to our meeting)

ASSETS AND LIABILITIES
INCOME

	Applicant		Applicant's Spouse	
Type	Amount	How often?	Amount	How often?
Social Security/ Railroad Retirement				
Veteran's benefits				
Pensions: ________________				
Employment				
Other: ________________				

Is Applicant and/or Spouse receiving any type of state or federal benefits other than retirement benefits?

If yes, details: ____

Did Applicant and/or Spouse file US income tax returns in the past three years? ______________________________

Does Applicant and/or Spouse expect to receive any **inheritances**? _____ Yes ____No

If yes, from whom? ________________________________
What is the approximate value(s)? $_________________

ASSETS

NOTE: A Medicaid application asks for information about all of these categories of assets. Few applicants have all of these different types of assets. If a particular category does not apply to your family, just write "NONE". Keep in mind that we will need to disclose all assets owned within the last 60 months, even if not still owned when the application is submitted.

BANK ACCOUNTS AND SAVINGS ACCOUNTS

In this section, we need information about every bank account the Applicant and/or Spouse currently has, including checking, savings, credit union, NOW, passbook, money-market, and CD's. We also need information about any such accounts that have been closed within the past 60 months.

Joint Accounts:

Name(s) on Acct	Name of Bank	Acct Number	Type of Acct	Current Balance	If closed, date closed

Applicant's Own Accounts:

Name(s) on Acct	Name of Bank	Acct Number	Type of Acct	Current Balance	If closed, date closed

Spouse's Own Accounts:

Name(s) on Acct	Name of Bank	Acct Number	Type of Acct	Current Balance	If closed, date closed

PENSION OR PROFIT SHARING PLANS (IRAs, 401(k)s, Keoghs, etc.)
Does Applicant and/or Spouse have any retirement accounts, including IRAs, Keoghs, or pension funds? If yes:

Type of Plan	Owner?	Name of Company	Account Number	Fair Market Value	Beneficiary(ies)

STOCKS, BONDS, AND MUTUAL FUNDS/OTHER
In this section, we need information about any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe deposit boxes, coins, stamps, and cash

# of shares	Name of Company	Description of Security	In whose name?	Fair Market Value	Basis	Amount of Income Rec'd

ANNUITIES:
Does the Applicant or Spouse own an annuity? If yes:

Name of Owner	Name of Annuitant	Purchase Price	When Purchased	Income Received	Beneficiary(ies)

STOCK OPTIONS:
Does the Applicant or Spouse have any stock options? If yes, please give details:

BUSINESS INTERESTS:
If the Applicant or Spouse has any interest in a partnership, joint venture, closely held corporation, proprietorship or other similar entity, we need complete information about its assets and liabilities, buy-sell agreements and all other related information including basis. Use the back side of this sheet, if necessary.

LIFE AND ACCIDENTAL DEATH INSURANCE

NAME OF INSURED	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE	ANY LOAN BALANCE?

TRUSTS:

Has the Applicant or Spouse ever created any trust? ______________________________

If yes, was the trust created with assets belonging to Applicant or Spouse? _____

Has the Applicant or Spouse transferred any properties including their home into a trust? _______

Has the Applicant or Spouse transferred any assets into trust for a disabled child or other disabled individual? ________

Has the Applicant or Spouse (or Trustee, on their behalf) transferred any trust assets for the benefit of anyone else? _____

Is the Applicant or Spouse the beneficiary of any trust? ____________________________

If yes, who created the trust? ____

If yes to any of above:

NAME OF TRUST	REVOCABLE OR IRREVOCABLE?	DONOR/ GRANTOR	TRUSTEE(S)	BENE-FICIARIES	WHEN CREATED?	TRUST PRINCIPAL

How much income does Applicant and/or Spouse receive from the trust(s)? _________________________________

PRE-PAID BURIAL OR FUNERAL PLANS:
In this section, we need information about any prepaid contract or trust or insurance policy or bank account designated for funeral and burial expenses:

NAME OF OWNER	TYPE OF PLAN	NAME OF COMPANY/BANK/ FUNERAL HOME	ACCOUNT/POLICY NUMBER	AMOUNT OF CONTRACT OR POLICY OR ACCOUNT

REAL ESTATE:

In this section, we need information about any ownership interest the Applicant and/or Spouse may have – or has had in the past 10 years – in any real estate, including their home, vacation property, rental property, time-sharing property, vacant lots, business property, whether in Massachusetts or out of state.

NAME(S) ON OWNERSHIP PAPERS	ADDRESS OF PROPERTY	TYPE	DATES OF OWNERSHIP	FAIR MARKET VALUE	PURCHASE PRICE	COST OF IMPROVE-MENTS	MORT-GAGE?

With regard to the Applicant's home:

Who lives there? ____

Relationship to Applicant: ____

If anyone other than the Applicant and Spouse lives in the home, how long has he/she/they lived there?
____

If any property listed above is rental or income producing property, how much rent do you receive? ____________

OTHER ASSETS:

Automobiles (model, make, fair market value, in whose name, outstanding loan?):
____
____

Boats, Trailers, etc. ____

Mortgages Owned, Land Contracts, or Other Receivables: _______________________________________
____

Law suit judgments: ____

Other assets:____
____
____

LIABILITIES

(including accounts payable, mortgages not listed above, promissory notes, judgments, charitable pledges)

Amount Owed	to Whom Owed	Due Date	Secured by What Asset

GIFTS AND OTHER ASSET TRANSFERS

NOTE: We need to disclose to the Division of Medical Assistance every gift, change of asset ownership, and transfer or sale for less than fair market value that the Applicant and/or Spouse has made in the 60 months preceding the date of application.

Has the Applicant or Spouse transferred:

Income? ________________

The right to income? _______________

Cash? ___________________________

Ownership in whole or in part in any other asset? ______________

Create any life estate? _______________________________

Give a mortgage? __________________________________

Add another name to any property/account? ______________

If yes to any of the above, please list:

TYPE OF ASSET	DATE OF TRANSFER	TRANSFERRED TO WHOM?	RELATIONSHIP TO APPLICANT	AMOUNT OF TRANSFER