Edelson Law LLC
GUARDING GENERATIONS

Zisl Edelson, J.D., M.B.A.
Estate Planning & Elder Law

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LONG TERM CARE PLANNING INTAKE FORM

A. PRIMARY CONTACT INFORMATION

Name:_____

Address:_____

Telephone:_____

Email:_____

Facsimile:_____

B. PERSONAL DATA

Husband Full Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ U.S. Citizen?_____ Veteran? Yes/No

Social Sec. # _____

Wife Full Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ U.S. Citizen?_____ Veteran? Yes/No

Social Sec. # _____

C. MEDICAL DATA

Name of Ill Spouse _____

Diagnosis _____

Prognosis _____

Course of Treatment _____

Where ill Spouse Currently Resides _____

Name of Well Spouse _____

Health of Well Spouse _____

Where Well Spouse Currently Resides _____

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the first date entered on a continuous basis _____

Daily Private Pay Rate: _____

Other:

D. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$_____	$_____
Retirement Benefits (Gross)	$_____	$_____
VA Disability Benefit	$_____	$_____
Annuity Income	$_____	$_____
Other Income	$_____	$_____
Total Monthly Income	$_____	$_____

Do not include IRA minimum distributions, interest and dividend income.

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

E. MONTHLY COST OF ASSISTED LIVING OR NURSING HOME

$_____ Monthly Base Cost

$_____ Monthly Incidental Cost

$_____ Monthly Prescription Cost

$_____ Monthly Other Cost

$_____ **Total Monthly Costs**

The assisted living/nursing home is paid through_____(month/year).

F. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12)

$_____ Rent/Mortgage

$_____ Real Estate Taxes

$_____ Water

$_____ Sewer

$_____ Utilities (Heat, Electric) (1/12 of last 12 months)

$_____ Homeowner's insurance premium

$_____ Condominium fees

$_____ **Total Monthly Housing Expenses**

G. MONTHLY NON-SHELTER EXPENSES

(Please estimate)

$_____ Food

$_____ Medical

$_____ Clothing

$_____ Telephone

$_____ Transportation (including auto insurance)

$_____ Home Maintenance

$_____ Life Insurance Premiums

$_____ Health Insurance Premiums

$_____ Medicare Supplemental Insurance Premiums

$_____ Cable TV

$_____ Federal and State Income Taxes

$_____ Other

$_____ **Total Monthly Non-Shelter Living Expenses**

H. ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Husband	Wife	Joint	Liabilities
AUTOMOBILE				
ADDITIONAL AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
IRA				
OTHER REAL ESTATE				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

For Attorney Only:

Total countable resources as of the first continuous period of institutionalization: $_____

I. BANK AND INVESTMENT ACCOUNT DETAILS

	Account Name (owner)	Institution/Bank	Acct. No.	Value/Date
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

J. ADDITIONAL BANK AND INVESTMENT ACCOUNT DETAILS

Account Name	Financial Institution	Acct. No.	Value/Date
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

K. LIFE INSURANCE

COMPANY NAME (include address and Policy No.)	TYPE	DEATH BENEFIT VALUE	Face Value	Cash Value	INSURED	OWNER	BENEFICIARY

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

L. GIFTS

Please list gifts made in excess of $100.00 in any one month, to an individual or group of individuals, within the past 60 months:

Recipient:_____ Date:_____ Amount:_____

Recipient:_____ Date:_____ Amount:_____

Recipient:_____ Date:_____ Amount:_____

Recipient:_____ Date:_____ Amount:_____

Recipient:_____ Date:_____ Amount:_____

Have you ever filed a United States Federal Gift Tax Return? Yes No

If so, please state details _____

_____

M. CHILDREN (if applicable)

CHILD'S NAME	ADDRESS (With Zip Code)	TELEPHONE NUMBER	DATE OF BIRTH

Are all of your children in good health?_____

Are any of your children receiving SSI or other forms of government entitlement?_____

Do any of your children live with you in your home?_____

Additional Information – Please list here any additional concerns and goals you may have for your spouse, your children, grandchildren and other loved ones:

_____

_____

_____

Questions – Please list here any additional questions you would like to discuss:

_____

_____

_____

Client Certification:

I hereby certify to Edelson Law, LLC, that all information in this form is true, correct and complete.

Client Signature: _____

Date: _____

Once completed, please return this form to:

Zisl Edelson, Attorney

Edelson Law, LLC
8401 Crawford Ave., Suite 104
Skokie, IL 60076
Ph. 847-410-9131
Fax. 847-745-0195

NOTES: