Boyer & Boyer, P.A.
Long Term Care Initial Intake Questionnaire

The information contained in the following questionnaire is essential for us to know so that we may properly plan for you. Please complete the form to the best of your ability. All of the information which you provide will remain a part of your client file and is confidential. Please note the term "client" generally refers to the ill or incapacitated individual.

Today's Date:_____

Name of Individual completing this form:_____

Relationship to Client (if not completed by Client):_____

Names of other persons attending this meeting:_____

Who referred you to our firm?_____

Have you or anyone in your family been to our firm before? If so, when?_____

Have you spoken to another attorney about this same matter? If so, who? _____

Name of person to be billed?_____

Preferred Method of Written Communication Mail ( ) E-mail ( ) Fax ( )

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Client's Name:_____

Currently living: Home _____ Nursing Home____ ALF _____ Date of admission_____

Name of Facility:_____

Home or facility address:_____

City:_____County:_____ State: _____ Zip_____

Home address if living in facility:_____

City:_____County:_____ State: _____ Zip_____

Phone:_____ Cell:_____ Email:_____

US Citizen ( ) Yes ( ) No Place of Birth:_____ Veteran ( ) Yes ( ) No

Date of Birth:_____ Social Security No.:_____

Spouse's Name:_____

If deceased, date of death:_____

Currently living: Home_____ Nursing Home or ALF_____ Date of admission_____

Home or facility Address:_____

City:_____ State: _____ Zip Code:_____

Home address if living in facility:_____

City:_____County:_____ State: _____ Zip_____

Phone: _____ Cell:_____ E-mail:_____

US Citizen ( ) Yes ( ) No Place of Birth:_____ Veteran ( ) Yes ( ) No

Date of Birth:_____ Social Security No.:_____

CONTACT PERSON - If other than spouse

Contact Name:_____Relationship to Client:_____

Address:_____Apt. #:_____

City:_____State:_____ Zip:_____

Phone No.'s: Home:_____Work:_____Fax:_____

Cell:_____

E-mail address:_____

Alternate E-mail address:_____

GENERAL INFORMATION ABOUT THE CLIENT

Are you currently ___married ___widowed ___divorced ___single

Number of prior marriages? ( ) husband ( ) wife

Date of current marriage._____

Is there a prenuptial agreement? ( ) Yes ( ) No

Do you own your home?_____ If yes, is there a mortgage?_____

Whose names are listed on the deed to the homestead property?_____

Do you have investment/rental property or a vacation home?_____

How many children do you have?_____

Are all the children of this marriage? ( ) Yes ( ) No

Is anyone in the client's family disabled? If so, whom:_____

Current/Previous Occupation? Husband:_____ Wife:_____

Please list the names, addresses and telephone numbers of all children and indicate whether they are the husband's children (H), the wife's children (W), or children of both (B). Please note if any of the children have died leaving children of their own (grandchildren).

Name Address Telephone number

_____

_____

_____

_____

Are you enrolled in a Medicare D program? If so, what is the name of the Program _____

Coverage for Client_____ Spouse_____ Monthly Premium $_____

Medical Supplemental Insurance Carrier _____

Coverage for Client_____ Spouse_____

Policy Number_____ Monthly Premium $_____

Long Term Health Care Insurance Carrier _____

Coverage for Client_____ Spouse_____Monthly Premium $_____

Benefit amount per day:_____ Elimination period:_____Coverage period in years:_____

Do you have a Will? yes __ no__ If yes, what is the date of the Will?_____

Where is the will kept?_____Who is the Personal Representative?_____

Who prepared the document for you?_____

Did you create a Revocable Living Trust? yes __ no__ If yes, date of the Trust?_____

Where is the Trust kept?_____ Who is/are the Trustee(s)?_____

Who prepared the document for you?_____

Are you the beneficiary of trust agreement(s) created by someone else? yes __ no__ Please attach a copy of the trust.

If yes, who established the trust?_____On what date?_____

Do you have a Health Care Directive/Living Will? Yes __ No__ If yes, what is the date?_____

Who have you named as your health care decision maker(s)?_____

Who prepared the document for you?_____

Who has current possession of the document?_____

Do you have a Durable Power of Attorney? Yes ___ No ___If yes, what is the date_____

Who is your designated as your Agent(s)? _____

Who prepared the document for you?_____

Who has current possession of the document?_____

GIFTS TO SOMEONE ELSE OTHER THAN A SPOUSE WITHIN THE LAST 60 MONTHS

Type of Asset: _____ Date of gift:_____ Amount:_____

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Type of Asset: _____ Date of gift:_____ Amount:_____

INCOME: Please list amounts of **gross (before taxes)** monthly income which apply to you and your spouse. Please bring documentation of income to initial meeting.

CLIENT		**SPOUSE**	
Work Earnings	_____	Work Earnings	_____
SS Retirement	_____	SS Retirement	_____
SS Disability	_____	SS Disability	_____
Veterans benefits	_____	Veterans benefit	_____
Private Pension	_____	Private Pension	_____
Public Employ. Pension	_____	Public Employ. Pension	_____
RR Retirement	_____	RR Retirement	_____
Rental Income	_____	Rental Income	_____
Annuity	_____	Annuity	_____
Interest & Dividends	_____	Interest & Dividends	_____
IRA income	_____	IRA income	_____
Other	_____	Other	_____

ASSETS: Please give an estimated value of the following assets excluding your home and car.

	Client	Spouse	Joint
Checking & savings	_____	_____	_____
Certificates of deposit	_____	_____	_____
Stocks, bonds, mutual funds	_____	_____	_____
Annuities	_____	_____	_____
IRA's	_____	_____	_____
Savings bonds	_____	_____	_____
Life insurance cash value	_____	_____	_____
Non-homestead real estate	_____	_____	_____

Other _____ _____ _____

What are your current expenses per month?

Housing Expenses (include mortgage, maintenance and condo fees, insurance):_____

Utilities:_____

Medical Expenses (including pharmacy):_____

What is current mental and physical health of the client:_____

_____

_____

What is the current mental and physical health of the spouse:_____

_____

_____

Do you anticipate the need to place client in a long term care facility within the next 12 months? _____

If so, when? _____

Do you have professional advisors? _____

	Name	Address	Phone
CPA	_____		
Insurance Advisor	_____		
Financial Advisor	_____		
Banker	_____		
Spiritual Advisor	_____		

What is your primary goal in seeking legal advice?

_____

_____

_____

_____

Additional information you feel we should know about the client and/or family:

_____

_____

_____

_____

_____

_____