

PRIMARY CONTACT INFORMATION

Date _____ File No. _____

Name _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Fax No. _____

E-Mail Address _____

This form is extremely important. Your accuracy and completeness in responding will help us best provide the proper direction to help you meet your concerns. All information provided on this form is considered personal and confidential and will not be shared without your permission.

CLIENT INFORMATION

(Husband)
Full Name _____
(Full Legal Name)

(Wife)
Full Name _____
(Full Legal Name)

Street Address _____

City _____ State _____ Zip _____

(Husband)
Birth Date _____

(Wife)
Birth Date _____

Social Security No. _____

Social Security No. _____

U.S. Citizen? Yes NoVeteran? Yes NoU.S. Citizen? Yes NoVeteran? Yes No

MEDICAL DATA

HEALTH

Health of Husband (include current diagnosis) _____

Where Husband Currently Resides _____

Type of Care Provided: None Home Care Assisted Living Skilled Nursing Facility

Amount of Time in Current Location _____

Health of Wife (include current diagnosis) _____

Where Wife Currently Resides _____

Type of Care Provided: None Home Care Assisted Living Skilled Nursing Facility

Amount of Time in Current Location _____

If Either Spouse is In Nursing Home

Does the Nursing Home Accept Medicaid Payments: Yes No

PHYSICIAN

Full Name of Husband's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

Full Name of Wife's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

PHARMACEUTICAL PLANS

If you are a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? Yes No

MONTHLY INCOME

| | Husband's Monthly Income | Wife's Monthly Income |
|---|-----------------------------|--------------------------|
| Social Security Benefits (include Medicare Part B Deduction, if applicable) | \$ _____ | \$ _____ |
| Retirement Benefits (Gross) | \$ _____ | \$ _____ |
| VA Disability Benefit | \$ _____ | \$ _____ |
| Annuity Income | \$ _____ | \$ _____ |
| Rental Income | \$ _____ | \$ _____ |
| Other _____ | \$ _____ | \$ _____ |
| TOTAL MONTHLY 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. Do not include interest and dividend income in this section of the form.

MONTHLY SHELTER EXPENSES

(Provide monthly amount only. Divide annual expenses by 12 and quarterly expenses by 4.)

| | | Frequency <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
|--|----------|--|
| Rent/Mortgage | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Real Estate Taxes | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Water | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Sewer | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Utilities (Heat, Electric & Telephone) | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Homeowner's insurance premium | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Condominium fees | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Total Monthly Shelter Expenses | \$ _____ | |

MONTHLY NON-SHELTER LIVING EXPENSES

(Provide monthly amount only. Divide annual expenses by 12 and quarterly expenses by 4.)

| | | Frequency |
|---|-----------------|---|
| Food | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Medical (include nursing home or assisted living) | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Clothing | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Transportation (including auto insurance) | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Home Maintenance | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Life Insurance Premiums | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Health Insurance Premiums | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Cable TV | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Federal and State Income Taxes | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Other | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |
| Total Monthly Non-Shelter Living Expenses | \$ _____ | <input type="checkbox"/> mo. <input type="checkbox"/> yr. <input type="checkbox"/> qtr. |

GIFTS

Have you made gifts to a trust, an individual, or group of individuals, within the past 60 months, or to a trust within the past 60 months? Yes No

If yes, list below:

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

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

If yes, please state details (attach additional sheets if necessary):

ASSETS/LIABILITIES

| ASSETS | HUSBAND | WIFE | JOINT | LIABILITIES |
|--------------------------------------|---------|------|-------|-------------|
| PERSONAL EFFECTS | | | | |
| AUTOMOBILE | | | | |
| CHECKING | | | | |
| | | | | |
| | | | | |
| SAVINGS | | | | |
| | | | | |
| | | | | |
| MONEY MARKET | | | | |
| | | | | |
| | | | | |
| CERTIFICATES OF DEPOSIT | | | | |
| | | | | |
| | | | | |
| RESIDENCE (ASSESSED VALUE) | | | | |
| COST BASIS (PURCHASE PRICE):\$ _____ | | | | |
| OTHER REAL ESTATE | | | | |
| ADDITIONAL AUTOMOBILES | | | | |

ASSETS/LIABILITIES (continued)

| ASSETS | HUSBAND | WIFE | JOINT | LIABILITIES |
|----------------------------------|---------|------|-------|-------------|
| BROKERAGE/CAP ACCOUNTS | | | | |
| | | | | |
| MUTUAL FUNDS | | | | |
| | | | | |
| STOCKS | | | | |
| | | | | |
| BONDS | | | | |
| | | | | |
| ANNUITIES | | | | |
| | | | | |
| | | | | |
| CASH VALUE - LIFE INSURANCE | | | | |
| | | | | |
| | | | | |
| TRADITIONAL IRA/RETIREMENT PLANS | | | | |
| | | | | |
| | | | | |
| ROTH IRA | | | | |
| NURSING HOME DEPOSIT | | | | |
| CONTINUING CARE CONTRACT DEPOSIT | | | | |
| PREPAID FUNERAL | | | | |
| OTHER: | | | | |
| TOTALS: | | | | |

CHILDREN

(Please include all adult and minor children. Use additional sheets if necessary.)

Name of Child _____ Gender: Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Date of Birth _____ Social Security # _____

E-mail Address _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlock

Relationship to Wife: Natural child Adopted Stepchild Child born out of wedlock

Marital Status: Single Married Divorced Children: _____

Name of Child _____ Gender: Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Date of Birth _____ Social Security # _____

E-mail Address _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlock

Relationship to Wife: Natural child Adopted Stepchild Child born out of wedlock

Marital Status: Single Married Divorced Children: _____

CHILDREN (continued)

Name of Child _____ Gender: Male Female

Street Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Date of Birth _____ Social Security # _____

E-mail Address _____

Relationship to Husband: Natural child Adopted Stepchild Child born out of wedlock

Relationship to Wife: Natural child Adopted Stepchild Child born out of wedlock

Marital Status: Single Married Divorced Children: _____

THE FOLLOWING QUESTIONS APPLY TO ALL CHILDREN LISTED ABOVE

Are all of your children in good health? Yes No

Are any of your children blind or disabled? Yes No

Are any of your children receiving SSI or other forms of government benefits? Yes No

If yes: How much is the child's monthly payment? \$ _____

Is the child receiving Medicaid or Medicare? Medicaid Medicare

Do any of your immediate family members have any problems with:

AIDS? Yes No

Drug Addiction? Yes No

Alcoholism? Yes No

Spendthrift (debt problems or tax liens)? Yes No

Marital Difficulty? Yes No

Do any of your children live with you in your home? Yes No

If yes, name of child(ren) _____

Are you a contributor to a 529 Plan? Yes No

Are you the trustee of an UGMA Account? Yes No

PRIMARY CONTACT AUTHORITY

Complete this section if the primary contact person is someone other than the client(s). Please provide authority documentation.

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Mobile # _____ Fax # _____

E-mail Address _____

- Authority: I have been named agent under power of attorney for one or both of the clients.
 I have been appointed guardian or conservator for one or both of the clients.

REFERRAL SOURCE

Please tell us how you learned about our services.

- Web site Internet search engine Link from another site Newsletter Advertisement
 Word of mouth Heard about you on the radio/television/YouTube Referred by someone
 I was referred by:

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Mobile # _____ E-mail Address _____

- Referral is: Attorney Financial Planner Previous Client Doctor CPA
 Social Worker Friend Family Member Other _____

Can we discuss this case with the person who referred you to our office?

By signing here, you authorize our office to discuss this case with the person who referred you to our office. This authorization can be rescinded at any time in writing.

Signature: _____ /_____/____ Printed Name: _____
DATE