CONSULTATION DATE:	

LONG TERM CARE PLANNING WORKSHEET

MUST COMPLETE AND BRING TO CONFERENCE

PRINT FULL NAME		
DATE OF BIRTH	[/ /] AGE:	[/ /] AGE:
DATE OF MARRIAGE		
U.S. CITIZEN	YES ☐ NO ☐	YES ☐ NO ☐
VETERAN	YES ☐ NO ☐	YES ☐ NO ☐
EMAIL		
HOME PHONE		
RESIDENCE ADDRESS		
CITY, STATE, ZIP		
COUNTY		
DESCRIBE OVERALL MEDICAL CONDITION		

IN A NURSING FACILITY OR ASSISTED LIVING?	YES ☐ NO ☐ ADMISSION DATE:	YES ☐ NO ☐ ADMISSION DATE:
NAME, ADDRESS AND PHONE NUMBER OF FACILITY	____________ ____________ ____________ ( ) ____________	____________ ____________ ____________ ( ) ____________

MONTHLY NURSING HOME OR ASSISTED LIVING COST	$	$
MONTHLY RX COST	$	$
TOTAL MONTHLY EXPENSES OTHER THAN NURSING HOME OR ASSISTED LIVING		

PRIMARY CONTACT:

NAME:	
ADDRESS:	
CITY, STATE, ZIP	
PHONE:	
EMAIL:	
RELATIONSHIP:	

CHILDREN

CHILD 1	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

CHILD 2	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

CHILD 3	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

CHILD 4	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

CHILD 5	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

CHILD 6	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

CHILD 7	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

CHILD 8	☐ HUSBAND ☐ WIFE ☐ BOTH
DOES THIS CHILD LIVE AT HOME WITH YOU? ☐ YES ☐ NO	
NAME	
ADDRESS	
IS THIS CHILD DISABLED?	

MONTHLY INCOME

	NAME:	NAME:	INCOME FROM JOINT ASSETS
EMPLOYMENT	$ /MONTH	$ /MONTH	$ /MONTH
SOCIAL SECURITY	$	$	
SSI (SUPP. SECURITY INCOME)	$	$	
PENSION	$__________ $__________	$__________ $__________	
IRAS OR KEOGH OR 401K			
ANNUITIES			
DIVIDENDS			
INTEREST			
MINERALS			
RENTAL			
VETERAN'S COMP./PENSION	$	$	
TOTAL			

HEALTH INSURANCE

	HEALTH INSURANCE		HEALTH INSURANCE
NAME AND ADDRESS OF COMPANY		NAME AND ADDRESS OF COMPANY	
TYPE OF INS.		TYPE OF INS.	
MONTHLY PREMIUM PAID		MONTHLY PREMIUM PAID	

IS ANYONE COVERED BY VA OR MILITARY HEALTH PROGRAMS? YES _____ NO ______

LIFE INSURANCE

PLEASE LIST ALL POLICIES FOR WHICH YOU ARE AN OWNER

LIFE INSURANCE POLICY #1			
COMPANY		BENEFICIARY:	
IS THIS TERM?		OWNER:	
FACE VALUE	$	CASH VALUE: (THE AMOUNT YOU COULD CASH IN FOR)	$ AS OF [/ /]

LIFE INSURANCE POLICY #1			
COMPANY		BENEFICIARY:	
IS THIS TERM?		OWNER:	
FACE VALUE	$	CASH VALUE: (THE AMOUNT YOU COULD CASH IN FOR)	$ AS OF [/ /]

LIFE INSURANCE POLICY #1			
COMPANY		BENEFICIARY:	
IS THIS TERM?		OWNER:	
FACE VALUE	$	CASH VALUE: (THE AMOUNT YOU COULD CASH IN FOR)	$ AS OF [/ /]

LIFE INSURANCE POLICY #1			
COMPANY		BENEFICIARY:	
IS THIS TERM?		OWNER:	
FACE VALUE	$	CASH VALUE: (THE AMOUNT YOU COULD CASH IN FOR)	$ AS OF [/ /]

ASSET INFORMATION

#1 DO YOU OWN A HOME? YES ☐ NO ☐

ADDRESS_______________

COUNTY_______________

VALUE_______________

MORTGAGE BALANCE_______________

NAME(S) ON DEED_______________

#2 IS YOUR NAME ON ANY DEED OTHER THAN YOUR HOME? YES ☐ NO ☐

ADDRESS_______________

TYPE (LOT, HOUSE, FARM LAND)_______________

VALUE_______________

MORTGAGE BALANCE_______________

NAME(S) ON DEED_______________

#3 DO YOU OWN ANY MINERAL RIGHTS? YES ☐ NO ☐

WHERE_______________

VALUE_______________

NAME(S) ON DEED_______________

#4 LIST ALL BANK ACCOUNTS

TYPE: _____CHECKING _____SAVINGS _____CD _____OTHER

WHAT BANK_______________

BALANCE_______________

LIST ALL BANK ACCOUNTS

TYPE: _____CHECKING _____SAVINGS _____CD _____OTHER

WHAT BANK_______________

BALANCE_______________

LIST ALL BANK ACCOUNTS

TYPE: _____CHECKING _____SAVINGS _____CD _____OTHER

WHAT BANK_______________

BALANCE_______________

#5 LIST ANY INVESTMENT ACCOUNTS

WHERE_______________

TYPE: _____REGULAR _____IRA

BALANCE_______________

NAME(S) ON ACCOUNT_______________

ASSET INFORMATION CONTINUED

#6 LIST ANY STOCKS NOT HELD IN AN INVESTMENT ACCOUNT

NAME____

NUMBER OF SHARES: ____

#7 LIST ANY SAVINGS BONDS AND VALUE ____

#8 DO YOU HAVE A BURIAL POLICY? YES ☐ NO ☐

WHERE____

VALUE____

#9 DO YOU HAVE AN ANNUITY? (OTHER THAN YOUR RETIREMENT) YES ☐ NO ☐

WHERE____

VALUE____

#10 DO YOU OWE ANY MONEY? YES ☐ NO ☐

#11 LIST ALL CARS, TRUCKS, AND OTHER VEHICLES AND THEIR VALUES:

____

____

____

#12 ARE YOU EXPECTING AN INHERITANCE? YES ☐ NO ☐

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?
(BRING COPIES TO THE MEETING)

DOCUMENT	FOR ____________________ (WRITE DATE OF DOCUMENT)	FOR ______ (WRITE DATE OF DOCUMENT)
LAST WILL AND TESTAMENT		
FINANCIAL POWER OF ATTORNEY		
HEALTH CARE POWER OF ATTORNEY		
LIVING WILL		
REVOCABLE LIVING TRUST		
IRREVOCABLE TRUST		

NAME AND ADDRESS OF PERSON WHO REFERRED YOU TO OUR OFFICE:

____

____

HAVE YOU VISITED OUR WEB SITE? _____ YES _____ NO

DO YOU HAVE ANY IDEAS FOR IMPROVING OUR WEB SITE? IF SO, PLEASE DISCUSS:

____

____

DISCLOSURE STATEMENT:

I/WE HEREBY CERTIFY THAT ALL THE ABOVE INFORMATION IS COMPLETELY TRUE AND ACCURATE TO THE BEST OF OUR KNOWLEDGE. WE HEREBY CERTIFY THAT WE HAVE MADE NO MISREPRESENTATIONS OR OMISSIONS OR OMISSIONS IN PROVIDING THIS INFORMATION. WE UNDERSTAND THAT THE LAW OFFICE OF RAYMON B. HARVEY, P.A. WILL RELY ON THE INFORMATION PROVIDED AND THAT OUR PLANNING WILL BE BASED UPON THE ABOVE STATED INFORMATION. IF WE HAVE INCORRECTLY STATED ANY OF THE ABOVE MATTERS OR HAVE NOT FULLY DISCLOSED OUR FINANCIAL AFFAIRS, WE UNDERSTAND THAT THE PLANNING MAY NOT BE APPROPRIATE, MAY NOT FULLY BENEFIT OUR NEEDS.

____
DATE

____
DATE