

## TO PROSPECTIVE CLIENTS OF ELDER LAW CAROLINA:

I would like to introduce myself and explain what we mean when we say "Elder Law Services." Most of our clients are interested in protecting their assets from the costs of long-term care, particularly nursing home care. It is especially important to a married couple when the spouse living at home will need those assets to live on. And most clients would choose to pass on a modest inheritance or the family home to the children. Some may want to provide for a disabled loved one without jeopardizing their eligibility for public benefits.

The process we go through in order to accomplish the Client's goals consists of collecting a great deal of information about your assets, analyzing the information, reviewing strategies that are available to help you in your particular situation and, if desired, preparing a custom designed Asset Preservation plan tailored to your assets and objectives. If appropriate we will also assist you in implementing this plan. In order to maximize preservation of your assets over your lifetime, we have to be knowledgeable about several areas of law including Medicaid and Veterans benefits eligibility rules and regulations, federal and state gift and estate tax law, trust and debtor/creditor law. It is a complex and confusing area.

Many friends, neighbors and even some professional advisors give advice without fully understanding the consequences in all these areas. Actions that appear to be advantageous for Medicaid planning (for example, transferring the home to the children) may cause costly unintended consequences later.

In most elder law consultations, a great deal of time is spent in the first meeting analyzing the client's assets and family situation and explaining the Medicaid rules. Once we have this information, we can then quote you a fee for any further services you may need. The timing of the consultation often determines what needs to be done. If it is likely that a loved one is going to a nursing home soon, or has already been admitted, then there are several strategies that will need to be implemented in a short time frame. If the clients are simply doing "pre-need" planning in a long-term horizon, then often the work entails preparing or upgrading the estate planning documents and deeds which include provisions for asset protection.

We charge a flat fee for the initial one hour Elder Law Consultation, payable at the time of the meeting by cash or check. We review the information regarding income, assets, medical information and family situation of the client, analyze this information and discuss Medicaid rules and likely options. If further services are indicated we try to quote a flat fee will be quoted for further services. In providing our services, we rely on the information you provide to us. We do not attempt to obtain or verify information from third parties.

# Elder Law Carolina

## CARE PLANNING QUESTIONNAIRE

Your Information is Secure and Kept Confidential

The undersigned hereby represents to Carole Spainhour, Attorney, PC, that the information contained in this intake form is accurate and complete, and that the undersigned understands that the attorney will rely on this information for the purposes of developing a plan for public benefits eligibility. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct and negative impact on eligibility.

It would be helpful if you would either mail or scan and email the completed form to us before our initial consultation. Please contact our office at (828) 255-1966 or [elderlegal2@att.net](mailto:elderlegal2@att.net) if you have any questions about this form or need assistance completing the requested information. The more complete and accurate your responses, the better we will be able to serve you.

The Client is the person for whom benefits are or will be sought, and may include a spouse depending on the circumstances. If the Client is unable to fully participate in the planning process, we will deal with the client's representative (spouse, power of attorney or child). However as a general rule the elder or disabled person is the person to whom the attorney owes a duty of loyalty, and their interest is paramount in this process.

### **Biographical Information**

Today's Date: \_\_\_\_\_

NAME (person for whom benefits are sought): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Email Address: \_\_\_\_\_

U.S. Citizen:  YES  NO If not, citizen of: \_\_\_\_\_

Employer: \_\_\_\_\_

Retirement Date: \_\_\_\_\_

Veteran:  YES  NO Branch \_\_\_\_\_

Dates of Service (approximate): \_\_\_\_\_

Service Connected Disability:  YES  NO

**SPOUSE NAME:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County of Residence: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Email Address: \_\_\_\_\_

U.S. Citizen:  YES  NO If not, citizen of: \_\_\_\_\_

Employer: \_\_\_\_\_

Retirement Date: \_\_\_\_\_

Veteran:  YES  NO Branch \_\_\_\_\_

Dates of Service (approx): \_\_\_\_\_

Service Connected Disability:  YES  NO

Prior Spouse:  YES  NO Length of Marriage: \_\_\_\_\_

Date of Death (if applicable): \_\_\_\_\_

**FAMILY:**

Date of Last Marriage: \_\_\_\_\_

No. of Children: \_\_\_\_\_  
(for both spouses - include predeceased)

*\*If the children named below are not from a joint marriage with current spouse, check the box for Husband or Wife's Child*

	Name of Child	Age	Address	Phone Numbers
<input type="checkbox"/> H <input type="checkbox"/> W				
<input type="checkbox"/> H <input type="checkbox"/> W				
<input type="checkbox"/> H <input type="checkbox"/> W				
<input type="checkbox"/> H <input type="checkbox"/> W				
<input type="checkbox"/> H <input type="checkbox"/> W				
<input type="checkbox"/> H <input type="checkbox"/> W				

**Names & Ages of Grandchildren:**

Name	Age	Name	Age

Are any of your children blind?  YES  NO                      Disabled?  YES  NO

Receiving SSI benefits?  YES  NO

Is anyone (other than your spouse) dependent upon you for support?  YES  NO

Have you or your spouse been married before?  YES  NO

If yes, do you or your spouse have any children from a previous marriage?  YES  NO

Do you or your spouse have children who have died leaving children?  YES  NO

Does anyone to whom you may be leaving part of your estate require any help or protection in managing money or other property?  YES  NO

Do you and your spouse have a pre-nuptial or post-nuptial agreement?  YES  NO

Have any of your children or brothers or sisters lived with you during the last two years?  YES  NO

**HAVE YOU OR YOUR SPOUSE EVER APPLIED FOR MEDICAID?**  YES  NO

**MEDICAL / DISABILITY:**

Are you or your spouse blind, disabled or receiving SSI?  YES  NO

If yes, please explain: \_\_\_\_\_

Are you or your spouse at risk for becoming seriously ill or disabled because of a medical condition or family history?  YES  NO

If yes, please explain: \_\_\_\_\_

Your Doctor's Name: \_\_\_\_\_

Your Spouse's Doctor: \_\_\_\_\_

Have you recently entered a hospital facility?  YES  NO

Name of the facility: \_\_\_\_\_

Level of Care?  Intermediate Care  Skilled Nursing  
 Rest Home/Asst. Living

Date of Admission? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of Discharge? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Diagnosis? \_\_\_\_\_

If married, have you or your spouse previously been in the hospital or nursing home for a combined stay of 30 days or more since September, 1989?  YES  NO

If yes, please give dates and name of facility: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**HEALTH INSURANCE**

Your Medicare Insurance Co. \_\_\_\_\_  
Your Spouse's Medicare Insurance Co. \_\_\_\_\_  
Insurance from Employer: \_\_\_\_\_  
Medicare Supplement: \_\_\_\_\_  
Long-Term Care Insurance: \_\_\_\_\_  
Other: \_\_\_\_\_

**TRANSFERS OR GIFTS – VERY IMPORTANT !!! Please Complete**

Have you or your spouse made any transfers or gifts of more than \$500 during the past five years?  YES  NO

If yes, please list or be prepared to provide dates/amounts at your consultation:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MONTHLY INCOME**

	<b>YOU</b>	<b>YOUR SPOUSE</b>	<b>JOINT</b>
Social Security NET of premiums	\$	\$	\$
Employment	\$	\$	\$
VA Benefits	\$	\$	\$
Private Pension	\$	\$	\$
IRA's, Annuities, Etc.	\$	\$	\$
Rents	\$	\$	\$
Business Interest	\$	\$	\$
Regular Support from Others	\$	\$	\$
Trust Income	\$	\$	\$
<b>TOTAL MONTHLY INCOME</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>

**MONTHLY SHELTER EXPENSES (Estimates OK)**

Rent/Mortgages	\$
Home Equity Loan	\$
Real Estate Taxes	\$
Water	\$
Sewer	\$
Utilities	\$
Home Owners Insurance	\$
Condominium Fees	\$
Other	\$
<b>TOTAL MONTHLY SHELTER EXPENSES</b>	<b>\$</b>

**MONTHLY NON-SHELTER EXPENSES (Estimates OK)**

Food	\$
Medical	\$
Clothing	\$
Transportation (including auto insurance)	\$
Home Maintenance	\$
Life Insurance Premiums	\$
Health Insurance Premiums	\$
Cable T.V.	\$
Federal & State Income Taxes	\$
Other	\$
<b>TOTAL MONTHLY NON-SHELTER EXPENSES</b>	<b>\$</b>

**MONTHLY NURSING HOME OR ASSISTED LIVING EXPENSE**

Monthly Nursing Home Cost	\$
Monthly Prescription Cost	\$
Monthly Incontinent Cost	\$
Monthly Other Cost	\$
<b>TOTAL MONTHLY NURSING HOME EXPENSES</b>	<b>\$</b>

The nursing home is paid through: \_\_\_\_\_ (Month) \_\_\_\_\_ (Year)



**Stocks / Bonds / Mutual Funds (NOT IRAs or other retirement plans)**

Issuer/Broker	Account Number (Last 4 Digits)	Value	In Whose Name?
		\$	
		\$	
		\$	
		\$	
		\$	

**TOTAL:**      \$ \_\_\_\_\_

**Retirement accounts (IRAs, 401ks etc)**

Company & Type	Current Value	In Whose Name?	Beneficiary
	\$		
	\$		
	\$		
	\$		

**TOTAL:**      \$ \_\_\_\_\_

**Annuities: Indicate whether Qualified (IRA or other) or Non-Qualified (not a retirement account)**

Company & Purchase Date	Current Value	Owned By?	Qualified - Yes or No?	Beneficiary
	\$			
	\$			
	\$			
	\$			

**TOTAL:**      \$ \_\_\_\_\_

**Prepaid Funeral or Burial Arrangements:** \_\_\_\_\_

**ANY Trusts**

<b>Description (Revocable, Irrevocable, Trust Account)</b>	<b>In Whose Name?</b>	<b>Current Value</b>
		\$

**Real Estate**

<b>Purchase Date</b>	<b>Purchase Price</b>	<b>Tax Value</b>	<b>In Whose Name?</b>
	\$	\$	
	\$	\$	
	\$	\$	
	\$	\$	

Please describe (*outstanding debt, to whom owed, etc.*) any mortgage or deed of trust to which any of these properties may be subject.

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**Life Insurance**

<b>Whose Life?</b>	<b>Company</b>	<b>Policy Number</b>	<b>Face Value</b>	<b>Cash Value</b>	<b>Beneficiary</b>
			\$	\$	
			\$	\$	
			\$	\$	
			\$	\$	

Please describe any loans on these insurance policies.

<b>Description</b>	<b>Current Balance</b>	<b>Monthly Payment</b>	<b>Maturity Date</b>
	\$	\$	
	\$	\$	

**Other Assets** (E.G. – Notes Receivable, Tax Refunds, etc.)

Type of Asset	Where Asset is Located	Value	In Whose Name?
		\$	
		\$	

Do you or your spouse have an interest in any business?  YES  NO

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Personal Property**

(Autos (licensed & unlicensed) RV's, boats, farming equipment, etc.)

Description	Value	In Whose Name?
	\$	
	\$	
	\$	
	\$	
	\$	
	\$	

**LIABILITIES**

(Mortgages, notes to banks, notes to others, or not listed above)

Description	Current Balance	Monthly Payment	Maturity Date
	\$	\$	
	\$	\$	
	\$	\$	
	\$	\$	

**Other Liabilities** (E.G. - Credit Cards, Accounts Payable, etc.)

Type of Liability	Current Balance	Monthly Payment	Maturity Date
	\$	\$	
	\$	\$	
	\$	\$	

**LEGAL**

Please Bring:	Date Executed	State Where Executed	Location of Originals
Last Will & Testament	_____	_____	_____
Durable Power of Attorney	_____	_____	_____
Health Care Power of Attorney (or Living Will)	_____	_____	_____
Revocable Living Trust	_____	_____	_____

Current tax bills for real estate (bring with you along with copies of documents listed above)

Are you or your spouse the beneficiary of any trust? (Bring a copy of trust)  YES  NO

Do you or your spouse expect an inheritance  YES  NO

I am the legally appointed guardian of: \_\_\_\_\_

I am serving as Agent under Power of Attorney for: \_\_\_\_\_

I am serving as Executor or Administrator of an estate  YES  NO

I am involved in a lawsuit or have reason to believe that I will be involved in a lawsuit  YES  NO

Other legal concerns: \_\_\_\_\_

\_\_\_\_\_

**EXPRESS WAIVER OF CONFIDENTIALITY**

All communications between the client and ELDERLAW CAROLINA/Carole Spainhour, PC are confidential and will not be disclosed to anyone without the client’s express written consent. However, the client (if the client is the party completing this questionnaire) may waive his or her right to confidentiality and authorize this firm to discuss his or her affairs and provide information and documentation to the persons or organizations designated below:

Family Members: \_\_\_\_\_

Advisors: \_\_\_\_\_  
(Accountants, brokers, insurance agents, etc.)

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**NON CLIENT IDENTIFICATION**

Please note that our office most often regards the person for whom benefits are sought as our client. In certain circumstances, we may also represent spouses. If you are not the client, please provide your name, address and relationship to the client.

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**BY WHOM WERE YOU REFERRED TO THIS OFFICE?**

Name: \_\_\_\_\_

Organization \_\_\_\_\_

Address, City, State, Zip \_\_\_\_\_