LAW OFFICE OF
ALYSSA MONTELEON

VIRGINIA OFFICE - 703-791-9618 – NEW YORK OFFICE - 914-236-4042
FAX - 866-521-8402 – INFO@MONTELEONLAW.COM

LONG-TERM CARE PLANNING QUESTIONNAIRE (MARRIED COUPLE)

Please review the following questionnaire and complete the form accurately. Providing correct and accurate information is crucial to the representation that we provide to you. This information will be used to prepare your estate plan. Please print all information clearly and provide all legal names.

PERSONAL INFORMATION

Your Name _____ Date of Birth _____

Spouse's Name _____ Date of Birth _____

Your SSN # _____ Spouse's SSN # _____

Address _____

City, State, ZIP _____

Home _____ Cell (you) _____

Other _____ Cell (spouse) _____

email (you) _____

email (spouse) _____

Occupation (or former occupation) – (H) _____

(W) _____

Are you a U.S. Citizen? _____ Is your spouse a U.S. Citizen? _____

Are you a Veteran? _____ Is your spouse a Veteran? _____

Date of Marriage _____ Is this your first marriage? _____

If not, is there a divorce or separation agreement? _____

How did you learn about our office? _____

LONG TERM CARE INSURANCE

Do you have long term care insurance? _____

Name of insurance company _____

Daily Benefit $_____ Number of Years _____ Home Health Benefit $_____

CHILDREN

Child's Full Legal Name	Address	Phone Number	Date of Birth

Does Husband have any children by a previous marriage? ☐ Yes ☐ No

Does Wife have any children by a previous marriage? ☐ Yes ☐ No

Are any of your children disabled? ☐ Yes ☐ No

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

Do any of your family members have any problems with:

- Aids? ☐ Yes ☐ No
- Drug Addiction? ☐ Yes ☐ No
- Alcoholism? ☐ Yes ☐ No
- Spend Thrift? ☐ Yes ☐ No
- Marital Problems? ☐ Yes ☐ No

GRANDCHILDREN

Child's Full Legal Name	Address	Parents	Date of Birth

LAST WILLS & TESTAMENT INFORMATION

DISTRIBUTIONS TO SPOUSE & CHILDREN

Do you wish to provide primarily for your spouse and secondarily for your children? ☐ Yes ☐ No

Do you wish to treat all of your children equally? ☐ Yes ☐ No

If no, why not? _____

DISTRIBUTIONS TO GRANDCHILDREN

If you have grandchildren, do you wish to leave a specific amount of money or a percentage of your estate to your grandchildren? ☐ Yes ☐ No

Do you wish to treat all of your children equally? ☐ Yes ☐ No

If no, why not? _____

DISTRIBUTIONS TO CHARITIES

Do you want to leave a specific amount of money or other assets to any charity? ☐ Yes ☐ No

Name of Charity	Address	Amount

DISTRIBUTIONS TO OTHERS

Do you want to leave a gift in your will to anyone other than those listed? ☐ Yes ☐ No

Name of Beneficiary	Address	Relationship	Amount

EXECUTORS

Whom do you want to serve as the Executor of your Will? Provide name, address, and phone number.

Husband

Primary Executor: ☐ Spouse ☐ Other _____

Substitute Executor 1: _____

Substitute Executor 2: _____

Wife

Primary Executor: ☐ Spouse ☐ Other _____

Substitute Executor 1: _____

Substitute Executor 2: _____

POWERS OF ATTORNEY

Whom do you want to make your financial decisions? Provide name, address, and phone number.

Husband

Primary Agent: ☐ Spouse ☐ Other _____

Substitute Agent 1: _____

Substitute Agent 2: _____

Wife

Primary Agent: ☐ Spouse ☐ Other _____

Substitute Agent 1: _____

Substitute Agent 2: _____

HEALTH INFORMATION

Ill Spouse ☐ Husband ☐ Wife

Diagnosis: _____

Prognosis: _____

Where is the Ill Spouse Living? _____

Is this a nursing home? ☐ Yes ☐ No If yes, date entered _____

Well Spouse ☐ Husband ☐ Wife

Health of Well Spouse: _____

Where is the Well Spouse Living? _____

Is this a nursing home? ☐ Yes ☐ No If yes, date entered _____

HEALTH INSURANCE INFORMATION

Husband's Primary Insurance

Name of Insurance Provider _____

Policy Number _____ Do you want to donate your organs or tissues? _____ Yes _____ No

Wife's Primary Insurance

Name of Insurance Provider _____

Policy Number _____ Do you want to donate your organs or tissues? _____ Yes _____ No

GROSS MONTHLY INCOME

	Husband	Wife
Social Security Benefits	$_____	$_____
Retirement Benefits	$_____	$_____
VA Disability Benefit	$_____	$_____
Annuity Income	$_____	$_____
Rental Income	$_____	$_____
Other Monthly Income	$_____	$_____

MONTHLY EXPENSES

Nursing Home Expenses $_____

Assisted Living Expenses $_____

In-Home Caregivers $_____

Prescriptions $_____

Health Insurance $_____

Long-Term Care Insurance $_____

Life Insurance Premiums $_____

ASSET INFORMATION

List the values of your current assets and attach a current statement for each.

Asset	Husband	Wife	Joint
Checking Accounts			
Savings Accounts			
Money Market Accounts			
CDs			
Automobiles			
Tax Assessed Value of the Home			
Tax Assessed Value of Other Real Property			
Stocks (Not in Brokerage Account)			

Bonds (Not in Brokerage Account)			
Mutual Funds (Not in Brokerage Account)			
Brokerage Accounts			
NON-IRA Tax Qualified Retirement Accounts			
IRAs			
Annuities			
Pre-Paid Funerals			
Other Assets			

LIFE INSURANCE

Company Name	Policy #/Type of Insurance	Insured/Owner	Face/Cash Values

OUTSTANDING DEBT

Creditor	Type of Debt (Mortgage, Credit Card, Etc.)	Outstanding Amount

GIFTS

Have you made any gifts in excess of $3,000 in any one month to an individual or group of individuals within the last 60 months? If so, please list below.

Recipient of Gift	Date of Gift	Amount

CERTIFICATION

The undersigned hereby represents to the Law Office of Alyssa Monteleon, PLLC, and each of its staff that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

_____ _____

Date Signature of Client or Client Representative