Thompson Tiemann
Estate & Financial Planning Questionnaire*
Date: _____

Person supplying answers to these questions: □ Husband □ Wife □ Other (Relationship: _____)

If Other: Name _____

Address _____

Phone – Day: _____ Night: _____ Mobile: _____

Fax: _____ Email: _____

Husband	**Wife**
Name	**Name**
Date of Birth	**Date of Birth**
Social Security No.	**Social Security No.**
Home Address	**Home Address**
County:	**County:**
Phone (Day)	**Phone (Day)**
Phone (Evening)	**Phone (Evening)**
Phone (Mobile)	**Phone (Mobile)**
Fax or Email:	**Fax or Email:**
Mailing address (if different from above)	**Mailing address (if different from above)**
Living Arrangements □ Own Home □ Rent-House/Apt. □ No Rent- Home of _____ □ Nursing Facility: _____ **Who else lives there (if not Nursing Home or ALF):**	**Living Arrangements** □ Own Home □ Rent-House/Apt. □ No Rent- Home of _____ □ Nursing Facility: _____ **Who else lives there (if not Nursing Home or ALF):**
Citizenship: □ U.S. □ Resident Alien □ Neither	**Citizenship:** □ U.S. □ Resident Alien □ Neither
Marital History □ Married for ___ years □ No previous marriage □ Previously married – Name of previous spouse: _____ Previous marriage ended in □ Divorce Date of Divorce _____ County of Divorce: _____ □ Death Date of Death _____	Marital History □ Married for ___ years □ No previous marriage □ Previously married – Name of previous spouse: _____ Previous marriage ended in □ Divorce Date of Divorce _____ County of Divorce: _____ □ Death Date of Death _____

Information Concerning Your Residence, If Owned By You:

Deed is in the name of: □ Husband □ Wife □ Both Husband & Wife

Estimated fair market value (tax appraised value if known): $_____

Amount owed on the mortgage: □ Nothing (paid off) □ Presently owe $_____

Location: _____

Who lives there now? □ Husband □ Wife □ Both Husband & Wife □ Other: _____

_____

Does your unmarried son or daughter live there? □ Yes □ No
Does your son or daughter who has provided care for you for 2 years live there? □ Yes □ No

Other information concerning your residence that may be important:_____

_____

_____

_____

_____

Information Concerning Your Other Assets

Definition of "Snapshot Date" and "Snapshot Value": On the first day of the first month when one spouse goes into a "medical institution" and stays at least 30 days, the Medicaid program takes a "snapshot" of all assets of both husband and wife. A "medical institution" is defined as a hospital, nursing home or rehabilitation facility (but not an Assisted Living Facility), and when there is a transfer from one medical institution directly to another, the time spent in both facilities counts toward the 30 days. Therefore, if one spouse went into a hospital on September 30, 1999 then transferred directly to a nursing home on October 10, 1999 and stayed in the nursing home at least until October 30, 1999, the "snapshot date" is September 1, 1999. *If there is not a "snapshot date" for either spouse, disregard the "snapshot date" column below. If both have snapshot dates, fill in the column for the spouse most likely to be in a medical institution in the future.*

"Snapshot date" for Husband, if any: _____

"Snapshot date" for Wife, if any: _____

Note: Valuations are net of liens (subtract anything you owe on the property. Life insurance is valued at Cash Surrender Value.

Resource Description	Title[1]	Snapshot Value	Most Recent Value	Most Recent Value Date
Residence				
Most Valuable Vehicle[2]				
Vehicle 2:				
Vehicle 3:				
Vehicle 4:				
Gravesite/Marker				
Prepaid Funeral Contracts				
Household Goods				
Checking Accounts: (Bank Name & Account #)				
Savings/CD's/Money Markets: (Bank Name, & Account #)				
Stocks/Bonds: (Brokerage Name & Account #)				

[1] Indicate "H" for Husband, "W" for Wife, "HW" for both Husband and Wife. Leave blank if uncertain. Please explain on the back if someone other than Husband and Wife own an interest in any asset.

[2] Enter year, make and model for all vehicles. Include any motorcycles, boats, trailers or RVs.

Resource Description	**Title**[1]	**Snapshot Value**	**Most Recent Value**	**Most Recent Value Date**
Notes Receivable:				
Real Estate (Other than residence, gas, oil, mineral rights, etc.)				

Life Insurance: Company Name & Policy #)	**Insured**	**Policy Owner**	**Face Value**	**Snapshot Cash Value**	**Current Cash Value**

Retirement Accounts (IRA's, 401k's, Deferred Comp, etc): (Company Name & Account #)	**Title**[1]	**Snapshot Value**	**Most Recent Value**	**Most Recent Value Date**
Annuity policies that are not currently paying out and are not in retirement accounts:				
Other (Describe):				
Safe Deposit Box				
Location & Contents				
Patient Trust Fund				
Attorney Use Only:				
Total Countable Resources				

Your Debts

Description	**Amount**
Homestead Debt	
Other Secured Debt	
Unsecured Debt	
Unsecured Debt	
Unsecured Debt	
Total Debt	

Do you own one or more credit cards? □ Yes □ No

Your Military Service

Have you, your spouse, parent(s), or deceased child(ren) ever been in the armed forces?
□ Yes □ No If yes, please provide the following:

Veteran's Name	**Service No./Branch**	**Relationship**	**Dates of Service**

Your Income

Please indicate monthly income:

FIXED INCOME:		
SOURCE	Husband	Wife
Social Security Net Monthly Payment		
Medicare Part B premium		
Medicare Part D premium		
Pension:		
Pension:		
VA:		
Other:		
Total		
VARIABLE INCOME:	Husband	Wife
Interest		
Dividends		
Salary		
Rent/Note		
Oil & Gas		
Other		
Total		
POSSIBLE DEDUCTIONS:	Husband	Wife
Tax withheld from pension (monthly)		
Monthly health insurance premium(s)		

Your Medical Expenses

Note: this is intended to be ompleted only for persons in a nursing home or Assisted Living Facility.

MONTHLY MEDICAL EXPENSE	**Husband**	**Wife**
Nursing Home or Assisted Living Facility (if any) cost		
Medications (out of pocket expense)		
□ Medicare Part A		
□ Medicare Part B		
□ Medicare Part D		
□ Medicare Supplement Insurance (or HMO) Company – Husband _____ Company – Wife _____		
□ Other Medical Insurance Type: _____ Company: _____		
□ Long Term Care Insurance		
Other Medical Expenses		

Other Questions Concerning Your Assets

Husband	**Wife**
Are you beneficiary of a trust? □Yes □No Transferred assets to a trust? □Yes □No Anticipate an inheritance? □Yes □No Received an inheritance? □Yes □No *(If Yes, be sure anything you still own is listed among your other assets above.)* Transferred cash or anything worth more than $2,000 as a gift, or for less than fair market value, in last 5 years? □Yes □No If Yes: Recipient: _____ Asset description: _____ _____ Date: _____ Value: $_____ Received in return: □ Nothing (Gift) □$_____Cash □ Other _____ Was the transfer motivated, at least in part, by need for Medicaid eligibility? □ Yes □ No If No, explain purpose(s) of transfer: _____	Are you beneficiary of a trust? □Yes □No Transferred assets to a trust? □Yes □No Anticipate an inheritance? □Yes □No Received an inheritance? □Yes □No *(If Yes, be sure anything you still own is listed among your other assets above.)* Transferred cash or anything worth more than $2,000 as a gift, or for less than fair market value, in last 5 years? □Yes □No If Yes: Recipient: _____ Asset description: _____ _____ Date: _____ Value: $_____ Received in return: □ Nothing (Gift) □$_____Cash □ Other _____ Was the transfer motivated, at least in part, by need for Medicaid eligibility? □ Yes □ No If No, explain purpose(s) of transfer: _____

Your Health

Physical/Mental Condition of Husband:	*Physical/Mental Condition of Wife:*
Diagnoses: _____ _____ _____ _____ _____ Medication(s): _____ _____ _____ _____ Nursing help you are getting now: _____ _____ _____ _____	Diagnoses: _____ _____ _____ _____ _____ Medication(s): _____ _____ _____ _____ Nursing help you are getting now: _____ _____ _____ _____
Activities you need help with (check all that apply): ☐Dressing ☐Bathing ☐Toileting ☐Moving Around ☐Eating ☐Taking Medication _____ _____ _____ _____ Mental status (check all that apply, even if only from time to time): Recognize friends & family: ☐Yes ☐No ☐Sometimes Can describe own property: ☐Yes ☐No ☐Sometimes Can name all family members: ☐Yes ☐No ☐Sometimes Comments: _____ _____ _____ _____ _____ _____	Activities you need help with (check all that apply): ☐Dressing ☐Bathing ☐Toileting ☐Moving Around ☐Eating ☐Taking Medication _____ _____ _____ _____ Mental status (check all that apply, even if only from time to time): Recognize friends & family: ☐Yes ☐No ☐Sometimes Can describe own property: ☐Yes ☐No ☐Sometimes Can name all family members: ☐Yes ☐No ☐Sometimes Comments: _____ _____ _____ _____ _____ _____

Attorney use only:				*Attorney use only:*			
Medicaid "medical necessity"?	☐Yes	☐No	☐Sometimes	Medicaid "medical necessity"?	☐Yes	☐No	☐Sometimes
Capacity to sign POA's?	☐Yes	☐No	☐Sometimes	Capacity to sign POA's?	☐Yes	☐No	☐Sometimes
Capacity to sign Will?	☐Yes	☐No	☐Sometimes	Capacity to sign Will?	☐Yes	☐No	☐Sometimes
Capacity to make gifts?	☐Yes	☐No	☐Sometimes	Capacity to make gifts?	☐Yes	☐No	☐Sometimes

Nursing Home/Hospital Information Pertaining to Husband (if applicable)

Please include all nursing homes, hospitals and rehabilitation facilities utilized by the *husband* on or after September 30, 1989:

Date In	Date Out	Name of Facility (& place if not Austin)	NH	Hospital	Rehab

If you are in a nursing home now—Is Medicare paying for your nursing home stay now?
□ Yes □ No

Nursing Home/Hospital Information Pertaining to Wife (if applicable)

Please include all nursing homes, hospitals and rehabilitation facilities utilized by the *wife* on or after September 30, 1989:

Date In	Date Out	Name of Facility (& place if not Austin)	NH	Hospital	Rehab

If you are in a nursing home now—Is Medicare paying for your nursing home stay now?
□ Yes □ No

Anticipated Future Need for Long Term Care

Husband	**Wife**
Hospital: □>6 mos. □1-6 mos. □<1 mo.	Hospital: □>6 mos. □1-6 mos. □<1 mo.
Nursing Home: □>6 mos. □1-6 mos. □<1 mo.	Nursing Home: □>6 mos. □1-6 mos. □<1 mo.
Assisted Living: □>6 mos. □1-6 mos. □<1 mo.	Assisted Living: □>6 mos. □1-6 mos. □<1 mo.
Home Care: □>6 mos. □1-6 mos. □<1 mo.	Home Care: □>6 mos. □1-6 mos. □<1 mo.

Life Expectancy

Husband	**Wife**
□ No known limit □ Less than 6 months according to physician □ Uncertain whether limited □ Other: _____	□ No known limit □ Less than 6 months according to physician □ Uncertain whether limited □ Other: _____

Your Family

Do you (or either of you) have one or more living children? ☐ Yes ☐ No

Do you have any grandchildren who are children of a deceased child of your? ☐ Yes ☐ No

List below your <u>children</u>. If a child of yours has died, <u>also</u> list his or her children (your grandchildren):

Name	Address	Phone	Disabled?[3]	Age	Whose?
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐Uncertain		☐ Husband ☐ Wife ☐ Both
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐Uncertain		☐ Husband ☐ Wife ☐ Both
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐Uncertain		☐ Husband ☐ Wife ☐ Both
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐Uncertain		☐ Husband ☐ Wife ☐ Both
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐Uncertain		☐ Husband ☐ Wife ☐ Both
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐Uncertain		☐ Husband ☐ Wife ☐ Both
Married? ☐ Yes ☐ No			☐ Yes ☐ No ☐Uncertain		☐ Husband ☐ Wife ☐ Both

Who now is providing significant assistance for –

Husband: ☐ Nobody ☐ Name(s): ______________________________

Wife: ☐ Nobody ☐ Name(s): ______________________________

Attorney use only:

Notes re family and other sources of support, conflict or difficulty

____

____

[3] A person is "disabled" for this purpose if he or she is unable, due to physical or mental disability, to engage in substantial gainful employment that exists in significant numbers in the national economy. If the person is presently receiving Social Security Disability, Supplemental Security Income (SSI), or Medicaid assistance for long term care, he or she does meet this requirement.

Questions Concerning Legal Documents

Document	Husband	*Attorney use only: Adequate?*	Wife	*Attorney use only: Adequate?*
Will	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Durable Power of Attorney (Financial)	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Power of Attorney for Health Care	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Directive to Physicians (Living Will)	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain
Living (Revocable) Trust	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain	☐ Yes ☐ No ☐ Uncertain

Attorney use only—Notes concerning legal documents:

Attorney Use Only:

Goals of client(s):

☐ Acquire the best possible long term care, within their financial ability
☐ Avoid impoverishment of the spouse at home
☐ Avoid having to sell certain assets: _____
☐ Acquire effective wills and powers of attorney
☐ Other: _____

_____

_____

Checklist for Plan Preparation:

How to obtain documents to copy:

- ☐ Client provided all copies needed
- ☐ We copied all at first conference
- ☐ Return original documents with plan after copying
- ☐ Call _____ to pick up documents after copying
- ☐ Have documents hand delivered to _____after copying

How to deliver plan:

- ☐ Call _____ to pick up at our office
- ☐ Have plan hand delivered to _____
- ☐ Have plan delivered by Fed Ex to _____
- ☐ Mail plan to the following: _____

*Thompson Tiemann gratefully acknowledges the original preparation of this form by Clyde Farrell of Farrell and Pac PLLC