THOMPSON & TIEMANN LLP
attorneys and counselors at law

LIFETIME PLANNING QUESTIONNAIRE

Date: _____

Please complete the following questionnaire to the best of your ability. This information will help us assist you with your lifetime and/or Medicaid planning. It will be held in the strictest confidence. (The "Client/Applicant" is the person for whom proposed planning is being discussed.) Please bring the following documents to our next meeting, if available: any estate planning documents you may have (such as Wills, Trusts, and/or Powers of Attorney); insurance policies; and any other documents or information you deem relevant. Finally, please review your records and provide all of the requested information to the best of your ability.

Personal Information	**Date of Birth**	**Social Security No.**

Name of Client/Applicant:

_____ _____ _____

Spouse (if any):

_____ _____ _____

Address:

_____

(Street, Town, State & Zip Code)

Home Tel: _____ Home Fax: _____
Cell Tel: _____ Other Tel: _____
Business Tel: _____ Business Fax: _____

Military Service:
Client/Applicant: _____ Spouse (if any): _____
U.S. Citizenship:
Client/Applicant: __ Yes Other_____ Spouse (if any): ____Yes Other_____

Health of Client/Applicant and Spouse (if any):

_____
_____
_____

PHONE (512) 335-6800 • FAX (512) 335-2088
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www.elderlawlink.com

Prior residence of Client/Applicant in a skilled nursing facility (nursing home), and/or any prior application for Medicaid? If so, give details: _____

_____

_____

Contact Person

Contact Person: _____

Relationship: _____

Address: _____
(Street, Town, Sate & Zip Code)

Home Tel: _____ Bus Tel: _____ Fax: _____

Children or Other Caregivers

_____
Name, Full Address, Home Tel. No., and Age

_____
Name, Full Address, Home Tel. No., and Age

_____
Name, Full Address, Home Tel. No., and Age

_____
Name, Full Address, Home Tel. No., and Age

_____
Name, Full Address, Home Tel. No., and Age

_____
Name, Full Address, Home Tel. No., and Age

Monthly Income (s)

Please list your estimated *monthly* income (s).

Income	Client/Applicant	Spouse (if any)	Total
Social Security			
Interest			
Dividends			
Pension Benefits			
IRA Benefits			
Rental Income			
Capital Gains (Losses)			
Other Taxable Income			
Other Non-Taxable Income			
TOTALS			

Monthly Health Care Expenses

Does Client/Applicant have or receive the following?

Medicare Part A _____ Part B _____

Supplemental Insurance?
If yes, company name: _____

Long Term Care Insurance?
If yes, company name: _____

Please list your estimated monthly health care expenses.

Expense	Client/Applicant	Spouse (if any)	Total
Home Care			
Health Ins. Premiums			
Prescription Medicines			
Nursing Home			
Other			
TOTALS			

List of Assets

Please provide a recap of **all** of your assets immediately below, together with any liability associated with a particular asset. (Married persons should list all assets, whether community or separate property.)

ASSET	EST. VALUE	LIABILITY
Personal Effects		
Automobile		
Checking Account		
Savings Account		
Money Market Account		
Certificates of Deposit		
Residence (Assessed value) Block # _____ Lot # _____ (Obtain from Tax Bill or Assessment)		
Other Real Estate		
Additional Automobiles		
Mutual Funds		
Stocks		
Bonds		
Annuities		
Cash Value-Life Insurance		
IRA		
Nursing Home Deposit		
Other		
Other		
TOTALS		

Gifts You Have Made

Include gifts made to others (such as family members, charities, churches, etc.) by Client/Applicant, or Client/Applicant's spouse (if any), since January 1, 2008. Also, please provide us with copies of any filed gift tax returns.

Maker (Donor)	Recipient (Donee)	Date of Gift	Value or Amount of Gift	Year Gift Tax Return Filed (if any)

Certifications

The undersigned understands that the personal and financial information provided in this form will be relied upon and used by Thompson Tiemann to assist with lifetime planning (including, by way of example, Medicaid Planning), and the undersigned hereby represents to said firm, that the information contained in this form is accurate and complete, and further understands that if the information contained herein is inaccurate or incomplete, the recommendations made by the attorney and law firm may not be appropriate. I also agree that a photocopy or scanned copy of the signed original will have the same effect as the signed original.

Certification dated the ___ of _____, 20__.

Signature of Client/Applicant or Client/Applicant's Representative:

_____

Client/Applicant or Representative

Revised 09-01-2013