Tampa Bay Elder Law Center
A PRIVATE LAW FIRM

3705 West Swann Avenue, Tampa, FL 33609
Phone: 813-282-3390 Fax: 813-902-3829
www.TampaBayElderLawCenter.com

LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

DATE: _____

SECTION 1. NAME AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

_____

Email Address: _____

Relationship to Client: _____

Client's Full Name: _____
(first) (middle) (last)

Spouse's Full Name: _____
(first) (middle) (last)

Home Address: _____

_____

Email Address: _____

	Client	**Spouse**
Telephone Numbers:	_____ (home)	_____ (home)
	_____ (cell)	_____ (cell)
Date of Birth:	_____	_____
Former/Maiden Names:	_____	_____
US Citizen?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Social Security Number:	_____	_____
Military Service:	_____	_____
Date of Death:	_____	_____

SECTION 2. MARITAL INFORMATION

A. Date of Marriage: _____

B. Place of Marriage: _____
(city) (state or province) (country)

C. Client's Former Spouses:

1. _____ (name of former spouse) _____ (date of marriage) _____ (place of marriage)
_____ (year terminated) [ ] Death [ ] Divorce (how terminated)
[ ] Yes [ ] No (still living?) _____ (if still living, describe relationship)

2. _____ (name of former spouse) _____ (date of marriage) _____ (place of marriage)
_____ (year terminated) [ ] Death [ ] Divorce (how terminated)
[ ] Yes [ ] No (still living?) _____ (if still living, describe relationship)

3. _____ (name of former spouse) _____ (date of marriage) _____ (place of marriage)
_____ (year terminated) [ ] Death [ ] Divorce (how terminated)
[ ] Yes [ ] No (still living?) _____ (if still living, describe relationship)

D. Spouse's Former Spouses:

1. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce _____
(year terminated) (how terminated) (place of termination)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

2. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce _____
(year terminated) (how terminated) (place of termination)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

3. _____ _____ _____
(name of former spouse) (date of marriage) (place of marriage)

_____ [ ] Death [ ] Divorce _____
(year terminated) (how terminated) (place of termination)

[ ] Yes [ ] No _____
(still living?) (if still living, describe relationship)

SECTION 3. CHILDREN

List all children. Copy and attach additional pages, if needed. Total number of children: _____

1. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

Email Address: _____

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

2. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

Email Address: _____

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

3. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

Email Address: _____

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

4. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

Email Address: _____

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

5. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

Email Address: _____

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

6. _____ _____ _____
(name of child) (date of birth) (social security number)

Parent: [ ] Client [ ] Spouse [ ] Both

_____ _____
(current address) (phone number)

Email Address: _____

[ ] Adopted _____ _____
(date of adoption) (court granting adoption)

[ ] Deceased _____ [ ] Yes [ ] No
(date of death) (child has surviving children?)

_____
(Describe this child -- does he or she have "special needs"? Consider health and general financial status, including needs and abilities)

_____
(Use additional pages, if needed)

SECTION 4. DISPOSITIVE PLANNING

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations. ***Please note that we expect that this will be completed during our first conference with you regarding estate planning. You may want to use this section as items to consider before our conference.***

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

A. First-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

_____

_____

B. Second-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

_____

_____

C. Third-choice beneficiaries: [ ] Spouse [ ] Children [ ] Spouse and Children [ ] Other

_____

_____

D. Any specific disposition of your residence?

_____

_____

E. Any specific gifts of special articles, such as art or jewelry?

_____

_____

F. Any specific disposition of household and personal effects?

_____

_____

G. Other information you think is important to your estate planning:

_____

_____

SECTION 5. FIDUCIARIES

Please consider who you want to handle your affairs when you cannot. ***We will discuss this section at our conference and will assist you with the completion.***

A. EXECUTORS (Co-Executors Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)

[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)

or [ ] Successor Executor

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)
[ ] Co-Executor with Previous Name (May surviving Co-Executor act alone? [ ] Yes [ ] No)
or [ ] Successor Executor

_____ _____
(current address) (phone number)

B. TRUSTEES (Co-Trustees Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)
[ ] Co-Trustee with Previous Name (May surviving Co-Trustee act alone? [ ] Yes [ ] No)
or [ ] Successor Trustee

_____ _____
(current address) (phone number)

C. GUARDIANS OF MINOR CHILDREN (Co-Guardians Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [ ] Yes [ ] No)
or [ ] Successor Guardian

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)
[ ] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [ ] Yes [ ] No)
or [ ] Successor Guardian

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)
[ ] Co-Guardian with Previous Name (May surviving Co-Guardian act alone? [ ] Yes [ ] No)
or [ ] Successor Guardian

_____ _____
(current address) (phone number)

D. AGENTS UNDER POWER OF ATTORNEY (Co-Agents Act: [ ] Separately or [ ] Jointly)

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)
[ ] Co-Agent with Previous Name (May surviving Co-Agent act alone? [ ] Yes [ ] No)
or [ ] Successor Agent

_____ _____
(current address) (phone number)

E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY

1. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

2. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

3. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

4. _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

SECTION 6. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

_____

_____

_____

B. Spouse

_____

_____

_____

SECTION 7. CAPACITY

A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: [ ] Yes [ ] No

Spouse: [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

B. OTHER ISSUES

	Client	Spouse
Able to sign name?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to speak?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to recognize friends and family?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Cognizant of property and possessions?:	[ ] Yes [ ] No	[ ] Yes [ ] No
Able to leave current residence?:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 8. PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of your primary physician.

	Client	Spouse
Physician's Name:	_____	_____
Specialty:	_____	_____

Address: _____ _____

_____ _____

Business Phone: _____ _____

SECTION 9. RESIDENCE -- OWNED

A. Owners: _____

B. How is title held? _____

PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL

C. Fair Market Value: $ _____

D. Mortgage Balance: $ _____

Is it a Reverse Annuity Mortgage (RAM)? [ ] Yes [ ] No

Basic Mortgage Terms: _____

E. Single Family Residence? [ ] Yes [ ] No

F. If the property is rental property, please provide the following:

1. Number of units: _____
2. Currently being rented? [ ] Yes [ ] No
3. Are tenants under lease? [ ] Yes [ ] No

G. If the property was purchased, please provide the following:

1. Date of Purchase: _____
2. Purchase Price: $ _____

H. If the property was inherited, please provide the following:

1. Month/Year Inherited: _____
2. Value when Inherited: $ _____

I. If improvements have been made to the property, please detail the value and nature of them:

_____

_____

_____

J. Have the owners used the capital gains tax exclusion? [ ] Yes [ ] No

K. If at least one occupant of the residence is a child of the individual in need of long-term care, has that child lived in the residence for at least 2 years? [ ] Yes [ ] No

1. If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? [ ] Yes [ ] No

2. If so, please describe the nature and duration of the care provided:

_____

_____

_____

L. Does the person needing care have any living children who are disabled? [ ] Yes [ ] No

If yes, please describe the nature of the disability:

_____

_____

M. Does the owner have a sibling who has lived in the house for at least 1 year? [ ] Yes [ ] No

If yes, does the sibling still reside in the home? [ ] Yes [ ] No

SECTION 10. RESIDENCE -- RENTED

A. Monthly Rent: $ _____

B. Type of Rental: [ ] Single Family [ ] Apartment [ ] Residential Care
[ ] Life Care [ ] Senior Housing

C. Rental/Lease Agreement? [ ] Yes [ ] No

D. Is Rent Subsidized? [ ] Yes [ ] No

If so, by whom and amount? _____

SECTION 11. LONG-TERM CARE (LTC)

A. Client

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

B. Spouse

Currently Receiving LTC? [ ] Yes [ ] No

If so, date started: _____

Name of Facility/Provider: _____

Address: _____

_____

Business Phone: _____

Administrator or Contact: _____

SECTION 12. HOSPITAL

A. Client

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

B. Spouse

Currently in Hospital? [ ] Yes [ ] No

If so, date admitted: _____

Name/location of hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? [ ] Yes [ ] No

If so, likely to return home? [ ] Yes [ ] No

SECTION 13. INCOME

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment vehicle is the "owner" of the income.

A. FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Social Security:	$	$	$
2.	R.R. Retirement:	$	$	$
3.	Pension:	$	$	$
4.	_____:	$	$	$
5.	_____:	$	$	$
6.	_____:	$	$	$

B. NON-FIXED MONTHLY INCOME

		Client	Spouse	Joint
1.	Interest:	$	$	$
2.	Dividends:	$	$	$
3.	_____:	$	$	$

4. _____: $ _____ $ _____ $ _____

5. _____: $ _____ $ _____ $ _____

C. TOTALS (A thru B): $ _____ $ _____ $ _____

SECTION 14 ASSETS AND RESOURCES

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)
(Please provide copies of statements)

Name of Bank/Branch	Account No.	Type of Account	Balance/Value	How Title Held
Big Bank/Main St. (sample)	123-45-6789	Savings	$ 85,321.87	Jointly w/ son
			$	
			$	
			$	
			$	
			$	

B. SECURITIES (Bonds, Marketable Securities, etc.)
(Please provide copies of statements)

Name of Company	Type of Sec.	# Shares/Face Val.	Cost	Current Val.	How Title Held
Acme Corp. (sample)	Common (or Preferred)	100 Shares	$ 5000	$ 9000	Sole owner
			$	$	
			$	$	
			$	$	
			$	$	
			$	$	

C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)
(Please provide copies of statements and beneficiary designations)

Name of Institution	Account No.	Owner	Beneficiary	Date Est.	Current Value
Big Broker (sample)	123-45-678	Client	Spouse	Jan, 1970	$ 85,000.00
					$
					$
					$
					$
					$

D. REAL ESTATE
(Please provide copies of deeds and most recent tax bills)

Description (Location)	Cost (Basis)	Market Value	Mortgage Bal.	How Title Held
123 Know Way (sample)	$ 120,000	$ 180,000	$ 85,321.87	Joint tenant
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	
	$	$	$	

E. PERSONAL PROPERTY

	Market Value	How Title Held
Home Furnishings:	$	
Cars, RVs, Boats, etc.:	$	
Jewels, Furs, etc.:	$	
: (other: collectibles, etc.)	$	

_____: $_____ _____

_____: $_____ _____

F. BUSINESS INTERESTS

If the person needing long-term care has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which the person needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

H. MISCELLANEOUS

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each.

_____

_____

_____

_____

_____

_____

SECTION 15. EXEMPT RESOURCES

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

	Client	**Spouse**
Burial plot:	[ ] Yes [ ] No	[ ] Yes [ ] No
Irrevocable burial fund contract:	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 16. PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

A. Responsible for Client:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

3. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

B. Responsible for Spouse:

1. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

2. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

3. _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

SECTION 17. UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

_____

_____

_____

SECTION 18. MONTHLY COST OF LIVING

A. HOUSING (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*:	$	$	$
2.	If home is rented, total rent, including maint. fees, if any:	$	$	$

* Is the senior citizen real property tax exemption being used? [ ] Yes [ ] No
Is the veterans real property tax exemption being used? [ ] Yes [ ] No

B. INSURANCE PREMIUMS (PER MONTH)

		Client	Spouse	Joint
1.	Health insurance:	$	$	$
2.	Long-term care insurance:	$	$	$
3.	_____ (specify):	$	$	$
4.	_____ (specify):	$	$	$

C. MEDICAL EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Non-covered medications:	$	$	$
2.	_____ (specify):	$	$	$
3.	_____ (specify):	$	$	$

D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)

		Client	Spouse	Joint
1.	Food:	$	$	$
2.	Entertainment and travel:	$	$	$
3.	Support for children:	$	$	$
4.	_____ (specify):	$	$	$
5.	_____ (specify):	$	$	$
E.	**TOTALS (A thru D):**	**$**	**$**	**$**

SECTION 19. HEALTH AND LTC INSURANCE

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

Name of Insurer	Policy No.	Type of Policy	Monthly Prem.	If LTC, Daily Benefit
Acme Insurance (sample)	123-45-6789	Long-term care	$ 3,000	$ 300.00 per day
			$	$
			$	$
			$	$
			$	$

SECTION 20. PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	Client	Spouse
Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
Revocable Living Trust:	[ ] Yes [ ] No	[ ] Yes [ ] No
Pour-Over Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
General Durable Power of Attorney:	[ ] Yes [ ] No	[ ] Yes [ ] No
Health Care Power of Attorney (or Proxy):	[ ] Yes [ ] No	[ ] Yes [ ] No
Living Will:	[ ] Yes [ ] No	[ ] Yes [ ] No
_____: (specify)	[ ] Yes [ ] No	[ ] Yes [ ] No
_____: (specify)	[ ] Yes [ ] No	[ ] Yes [ ] No
_____: (specify)	[ ] Yes [ ] No	[ ] Yes [ ] No

SECTION 21. TRANSFERS WITHIN 60 MONTHS

Has the person needing care transferred property to someone other than his or her spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**:

A. Client

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____
4.	_____	$ _____	_____

B. Spouse

	Recipient	Amount/Value of Gift	Date of Gift
1.	_____	$ _____	_____
2.	_____	$ _____	_____

3. _____ $ _____ _____

4. _____ $ _____ _____

SECTION 22. TRANSFERS TO OR FROM TRUSTS

Has the person needing care transferred property into a Trust, or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

A. Client

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

B. Spouse

	Name of Trust	Amount/Value of Transfer	Date of Transfer
1.	_____	$ _____	_____
2.	_____	$ _____	_____
3.	_____	$ _____	_____

SECTION 23. CLIENT'S GOALS

What are your goals?

_____

_____

_____

_____

_____

_____

_____

_____

_____

VA CLAIM QUESTIONNAIRE

(Only to be completed for Veterans or their surviving spouses)

CLAIMANT INFORMATION

Full name of veteran: _____

Full name of spouse: _____

Is spouse a veteran? □ yes □ no

Previous claim filed? □ yes □ no File # _____

SERVICE INFORMATION

Has the veteran received any of the following? (check all that apply)

- □ Lump Sum Readjustment Pay $ _____
- □ Separation Pay $ _____
- □ Special Separation Benefit $ _____
- □ Voluntary Separation Incentive $ _____
- □ Disability Severance Pay $ _____

The veteran is (check all that apply):

- □ on Medal of Honor Roll
- □ receiving VA compensation for service-connected disability
- □ receiving military retirement pay $ _____ branch: _____
- □ formerly a POW (please give a short description below)

_____

_____

_____

DISABILITY INFORMATION

Check all that apply

Veteran	Spouse	
□	□	Over 65
□	□	Blind
□	□	Declared incompetent
□	□	Has macular degeneration – Extent: _____
□	□	Under 65, determined disabled by Social Security Admin.
□	□	Diagnosed with dementia – Stage: Early Mid Late
□	□	Is housebound (unable to leave without assistance)
□	□	Needs daily assistance from another to perform basic activities
□	□	Receives Medicaid – Type: _____
□	□	Has applied for Medicaid – Type: _____
□	□	Is in a nursing home – Name: _____
□	□	Is in an assisted living facility – Name: _____

Has the claimant been hospitalized in the last 12 months? □ yes □ no

Began ___/___/_____ Ended ___/___/_____

Name and address of facility: _____

_____

Began ___/___/_____ Ended ___/___/_____

Name and address of facility: _____

_____

Please list the names and addresses of all physicians providing care to the veteran or spouse:

Name: _____ Address: _____

_____

Name: _____ Address: _____

_____

Will the veteran or spouse receive income in the next 12 months from:

Business operation or rental property	□ yes □ no
Farm operation	□ yes □ no
Personal injury settlement	□ yes □ no
Anticipated inheritance	□ yes □ no

If yes, please attach amounts to be received and any documentation showing amount received.

Are there any one-time or non-monthly sources of income the claimant expects to receive in the next 12 months? □ yes □ no If so, please explain:

_____

_____

_____

_____

Please list your monthly medical out-of-pocket expenses (if married, please include spouse's medical expenses as well). Medical expenses include prescriptions, home health aides, assisted living expenses, long term care premiums, doctor co-pays, etc.:

Expense	Amount paid monthly
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____