Senior Benefits Planning
Client Questionnaire

Gary Crooms – Senior Benefits Planner
Leigh Hilton, PLLC
918 N. Elm St. Ste 100 Denton, TX 76201

Responsible Party:

This information is being provided by (your name here): _____

Relationship to the person(s) seeking benefits / estate planning: _____

Your mailing address: _____

_____

Your daytime telephone number: _____

Your email address: _____

Does the person seeking benefit planning have Durable P.O.A or Guardianship? Check One:

❒ P.O.A. ❒ Guardianship ❒ Neither

Has a Health Care agent been appointed? ❒ Yes ❒ No

Has a Living Will (Directive to Physicians) been established? ❒ Yes ❒ No

Does this person(s) have a Last Will & Testament? ❒ Yes ❒ No

Revocable Trust? ❒ Yes ❒ No Irrevocable Trust? ❒ Yes ❒ No

_____ _____

Name of P.O.A. (if other than listed above) P.O.A. Phone

Applicant:

Please provide information regarding the individual(s) who is requiring care, or will potentially be entering an assisted living community, or long term health care facility:

Name: ❒ Mr. ❒ Mrs. _____

Mailing address: _____

_____

Date of Birth ____/____/____ Is this person a veteran, or widow of a veteran? ❒ Yes ❒ No

Marital Status: ❒ Married ❒ Single ❒ Widowed

Date of Admission to hospital or nursing facility, whichever was first: ____/____/____

Current care environment (check one):

❒ at home, no assistance needed ❒ at home, with home health assistance

❒ in personal care home ❒ in assisted living facility

❒ in nursing home ❒ in hospital / skilled care facility

Monthly Fixed Cost of Care: $ _____ Other monthly expenses (medicines, etc.): $_____

Home Living Expenses: $_____

Brief description of applicant's current health status:

_____

_____

_____

Spouse (if applicable):

Name: ❒ Mr. ❒ Mrs. _____

Mailing address: _____

_____

Date of Birth _____/_____/_____ Is this person a veteran? ❒ Yes ❒ No

Marital Status: ❒ Married ❒ Single ❒ Widowed

Date of Admission to hospital or nursing facility, whichever was first: _____

Currently care environment (check one):

❒ at home, no assistance needed ❒ at home, with home health assistance

❒ in personal care home ❒ in assisted living facility

❒ in nursing home ❒ in hospital / skilled care facility

Monthly Fixed Cost of Care: $ _____ Other monthly expenses (medicines, etc.): $_____

Home Living Expenses: $_____

Brief description of this person's current health status:

_____

_____

_____

Property (Applicant & Spouse):

Asset	Location/ Description	Owner	Value	Amount owed
Homestead				
Other Real Estate				
Other Real Estate				
Other Real Estate				
Automobile #1				
Automobile #2				
Automobile #3				

Asset	Location/ Description	Owner	Current Value	Current Liability
Oil / Mineral Rights				
Livestock / Poultry				
Personal Property				
Pre-need Funeral #1				
Pre-need Funeral #2				
Burial Plot #1				
Burial Plot #2				
Other				
Credit Card Liability				
Medical Bill Liability				
Personal Loans				
Other Liability				

Investment and Bank Accounts:

(i.e. checking, savings, CDs, mutual funds, stocks/bonds,

IRAs, 401K pension funds, annuities)

	Type of Account	**Institution**	**Owner**	**Current Balance**
(EX:	*Checking Account*	*Bank of America*	*Bill Jones*	*$ 13,500)*
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Monthly Income of Applicant / Spouse:

	Source of Income	**Payee**	**Gross Amount**	**Net Amount**
(EX:	*Social Security*	*John Smith*	*$816.90*	*$712.00)*
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Insurance (Applicant & Spouse)

Life Insurance:

Company	**Death Benefit**	**Cash Value**	**Insured / Owner**	**Beneficiary**	**Monthly Premium**
EX: *(Prudential*	*$25,000*	*$8,500*	*John Smith*	*Mary Smith*	*$50 / month)*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Applicant Health Insurance:

If currently receiving Medicare covered care: Number of days already paid by Medicare: _____

Number of days remaining of 100 total: _____

Covered by a Medicare Supplement? ❒ Yes ❒ No Monthly Premium: _____

Covered by a Medicare HMO? ❒ Yes ❒ No Monthly Premium: _____

HMO Carrier: _____

Spouse Health Insurance:

If currently receiving Medicare covered care: Number of days already paid by Medicare: _____

Number of days remaining of 100 total: _____

Covered by a Medicare Supplement? ❒ Yes ❒ No Monthly Premium: _____

Covered by a Medicare HMO? ❒ Yes ❒ No Monthly Premium: _____

HMO Carrier: _____

Applicant Long Term Care Insurance:

Long Term Care Insurance? ❒ Yes ❒ No Monthly Premium: _____

Elimination Period: _____ days Daily Benefit: _____

Maximum benefit: _____ If you are receiving LTC benefits, when did this begin? _____

Spouse Long Term Care Insurance:

Long Term Care Insurance? ❒ Yes ❒ No Monthly Premium: _____

Elimination Period: _____ days Daily Benefit: _____

Maximum benefit: _____ If you are receiving LTC benefits, when did this begin? _____

Gifts / Transfers of money or property (made in the last 5 years):

Amount of gift / transfer	To Whom?	Transfer Date (month / year)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Background

Client's Children	Location / City	Marital Status	# of Children

Does the client have any adult disabled children? ❒ Yes ❒ No
If so, please provide a brief description:

_____
_____
_____

Please review this list and provide copies of any of these documents and/or statements that apply to you. These are necessary to accurately complete your Senior Benefits Plan.

	(Please leave this column blank) **VERIFIED**
Last Will and Testaments	
Revocable Trust	
Irrevocable Trust	
Financial Powers of Attorney	
Healthcare Powers of Attorney	_____
Guardianship Orders	_____
Living Wills	_____
Burial Plots (deeds to cemetery property)	_____
Pre-need Funeral Plans	_____
Bank Account statement (most recent)	_____
Stock portfolio statements (most recent)	_____
All insurance policies (health, life, Medicare supplement, long term care)	_____
	_____
Real Estate property values (tax statement or market appraisal)	_____
Real Estate Deeds showing current owner(s)	_____
Real Estate Notes (notes owed to you)	_____
Oil, gas mineral, surface rights owned or leased	_____
Deeds showing Life Estate Interest	_____

Has any friend or relative included the Medicaid applicant or spouse as an heir to any portion of their estate? ❒ Yes ❒ No If yes, please provide details:

_____
_____
_____

Who may we thank for referring you to our firm?

_____
_____

What result do you expect from the planning provided by Leigh Hilton, PLLC? (i.e., preserving the family's estate, avoiding unnecessary nursing home expenses, etc.)

_____
_____
_____

The information provided herein to Leigh Hilton, PLLC is complete and accurate. I understand that Leigh Hilton is under no obligation to further investigate and verify the accuracy of this data, and that Leigh Hilton will formulate and base its recommendations on the data provided on this form.

X_____ _____
(Signature of responsible family party) Date

_____
(Print your name here)