



**FERNANDEZ**  
ELDER LAW LLC

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Date: \_\_\_\_\_

**LONG TERM PLANNING QUESTIONNAIRE**  
**CONFIDENTIAL INFORMATION**

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**Instructions | Please print clearly**

Please complete this form to the best of your ability so that we may provide the most informative consultation. Print additional pages if needed. This information is confidential.

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If someone other than the person seeking services is completing this form, please provide:

Name: \_\_\_\_\_

Relationship to the person seeking services: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_



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**LONG TERM PLANNING QUESTIONNAIRE**  
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**INFORMATION  
ABOUT THE  
PERSON  
SEEKING  
SERVICES**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Retirement Date: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

U.S. Citizen: Yes  No

Has the person ever applied for any type of government assistance/benefits? Yes  No

If yes, list the type and date of application (i.e. Medicaid, Veterans' Benefits, SSI, SSDI, etc.):

\_\_\_\_\_

Has the person had any contact with the Family Support Division (Medicaid)? Yes  No

If yes, please provide date and contact: \_\_\_\_\_

\_\_\_\_\_

Has the person ever had a stay in a hospital/rehab/nursing home for a period of at least 30 consecutive days? (This can be a combination of hospital/rehab/nursing home or just hospital or just rehab/nursing home stays for a continuous 30-day period. Please consider any 30-day stay during his/her lifetime.) Yes  No

If yes, please indicate date and location: \_\_\_\_\_

\_\_\_\_\_



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ABOUT THE  
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Is the person currently residing in a facility? Yes  No

Name of facility \_\_\_\_\_

Address: \_\_\_\_\_

Level of care: \_\_\_\_\_ Type of facility: \_\_\_\_\_

Date of admission: \_\_\_\_\_ Funding source(s): \_\_\_\_\_

Health status: \_\_\_\_\_

Is there a Social Worker at the facility with whom the person has been working? Yes  No

If yes, please provide a name and phone number: \_\_\_\_\_

Has the person ever been hospitalized for psychiatric reasons? Yes  No

If yes, please provide date and location: \_\_\_\_\_

Is the person under the treatment of a psychiatrist? Yes  No

If yes, please provide the doctor's name, address, and phone number: \_\_\_\_\_

\_\_\_\_\_

**FAMILY  
INFORMATION**

**Spouse**

If deceased, only  
name and date of  
death are needed

Spouse #1 Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_

If deceased, date of death: \_\_\_\_\_ If divorced, date of divorce: \_\_\_\_\_

Spouse #2 Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_

If deceased, date of death: \_\_\_\_\_ If divorced, date of divorce: \_\_\_\_\_



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**FAMILY  
INFORMATION**

**Children**

If deceased, only  
name and date of  
death are needed

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_

If deceased, date of death: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_

If deceased, date of death: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_

If deceased, date of death: \_\_\_\_\_



**FAMILY  
INFORMATION**

**Children**

Do any of the children have special needs (i.e., mental or physical disabilities)?

Child's Name: \_\_\_\_\_ Special Need: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Special Need: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Special Need: \_\_\_\_\_

Does the person have a Special Needs Trust for his/her child(ren)? Yes  No

Do any family member(s) currently live in the home? Yes  No

If yes, does the person provide support to that family member(s)? Yes  No

Describe the circumstances and reason for the arrangement. Explain how the situation is handled financially. Provide name(s), relationship to the Party, and the amount of monthly support:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REAL ESTATE**

Address: \_\_\_\_\_

Name(s) on Deed: \_\_\_\_\_

Date of Purchase: \_\_\_\_\_ Purchase Price: \$ \_\_\_\_\_

Mortgage Balance: \$ \_\_\_\_\_ Market Value: \$ \_\_\_\_\_

Beneficiary Deed: \_\_\_\_\_

Address: \_\_\_\_\_

Name(s) on Deed: \_\_\_\_\_

Date of Purchase: \_\_\_\_\_ Purchase Price: \$ \_\_\_\_\_

Mortgage Balance: \$ \_\_\_\_\_ Market Value: \$ \_\_\_\_\_

Beneficiary Deed: \_\_\_\_\_



**VEHICLES**

Make/Year: \_\_\_\_\_

Name(s) on Title: \_\_\_\_\_

Loan Balance: \$ \_\_\_\_\_ Market Value: \$ \_\_\_\_\_

Transfer on Death: \_\_\_\_\_

Make/Year: \_\_\_\_\_

Name(s) on title: \_\_\_\_\_

Loan Balance: \$ \_\_\_\_\_ Market Value: \$ \_\_\_\_\_

Transfer on Death: \_\_\_\_\_

**ACCOUNTS &  
INVESTMENTS**

**Savings  
Account(s)**

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Balance: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Balance: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

**Checking  
Account(s)**

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Balance: \$ \_\_\_\_\_

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Balance: \$ \_\_\_\_\_



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**ACCOUNTS &  
INVESTMENTS**  
**Bank Certificate  
of Deposit**

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

**Mutual Funds**

Name of Fund: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Name of Fund: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

**Stocks & Bonds**

Name of Brokerage Co.: \_\_\_\_\_

Purchase Date: \_\_\_\_\_ # of Shares: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Name of Brokerage Co.: \_\_\_\_\_

Purchase Date: \_\_\_\_\_ # of Shares: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Name of Brokerage Co.: \_\_\_\_\_

Purchase Date: \_\_\_\_\_ # of Shares: \_\_\_\_\_ Value: \$ \_\_\_\_\_

Name of Brokerage Co.: \_\_\_\_\_

Purchase Date: \_\_\_\_\_ # of Shares: \_\_\_\_\_ Value: \$ \_\_\_\_\_



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**ACCOUNTS &  
INVESTMENTS**

**IRAs, Keoughs,  
401(k) Plans,  
Annuities, etc.**

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Bank: \_\_\_\_\_ Account #: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

**Other  
Investments**

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_





**ACCOUNTS &  
INVESTMENTS**

**Other  
Investments**

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_

Bank: \_\_\_\_\_ Account Type: \_\_\_\_\_

Name(s) on Account: \_\_\_\_\_

Value: \$ \_\_\_\_\_

Payable on Death Beneficiaries: \_\_\_\_\_



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**INSURANCE**

**Life**

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Whole  Term

Policy Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Beneficiary: \_\_\_\_\_ Contingent Beneficiary: \_\_\_\_\_

Value: \$ \_\_\_\_\_ Cash Surrender Value: \$ \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Whole  Term

Policy Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Beneficiary: \_\_\_\_\_ Contingent Beneficiary: \_\_\_\_\_

Value: \$ \_\_\_\_\_ Cash Surrender Value: \$ \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_

**Supplemental**  
Include  
Long-Term  
Care Policies

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Value: \$ \_\_\_\_\_ Duration: \_\_\_\_\_

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Value: \$ \_\_\_\_\_ Duration: \_\_\_\_\_

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Value: \$ \_\_\_\_\_ Duration: \_\_\_\_\_



**INSURANCE**

**Health  
Spouse #1**

Check all that apply:  Medicare

Medicare Supplemental Insurance

Company: \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

How is the premium paid? \_\_\_\_\_

Company: \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

How is the premium paid? \_\_\_\_\_

**Health  
Spouse #2**

Check all that apply:  Medicare

Medicare Supplemental Insurance

Company: \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

How is the premium paid? \_\_\_\_\_

Company: \_\_\_\_\_ Monthly Premium: \$ \_\_\_\_\_

How is the premium paid? \_\_\_\_\_

**PREPAID  
FUNERAL**

Funeral Home: \_\_\_\_\_

Is this plan irrevocable? Yes  No

Owner: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

**OTHER  
ASSETS**

Is the person the beneficiary or grantor of any Trust: Yes  No

If yes, please attach a photocopy of a signed version if available or provide any details you can regarding the terms and conditions, identity of the current trustee, amount of principal, etc.

\_\_\_\_\_  
\_\_\_\_\_



**OTHER ASSETS**

During the last 60 months has the person made any gifts (\$1,000 or more in value), placed property into a trust, transferred real estate or other property for less than fair market value, or removed or added names to joint accounts?

Yes  No

If yes, please list each action and explain when and why the transfer was made:

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**MONTHLY INCOME**

**Spouse #1**

Employment: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Social Security Retirement: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Social Security Disability: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Supplemental Security Income: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Veteran's Benefits: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Private Pension: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Annuity: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Other Income: \_\_\_\_\_ \$ \_\_\_\_\_ /month

Other Income: \_\_\_\_\_ \$ \_\_\_\_\_ /month

To the extent not already noted above, please describe any significant changes that you anticipate occurring with respect to your financial or personal situation. \_\_\_\_\_

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**MONTHLY  
INCOME**

**Spouse #2**

Employment: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Social Security Retirement: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Social Security Disability: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Supplemental Security Income: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Veteran's Benefits: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Private Pension: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Annuity: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Other Income: \_\_\_\_\_ \$ \_\_\_\_\_ /month  
Other Income: \_\_\_\_\_ \$ \_\_\_\_\_ /month

To the extent not already noted above, please describe any significant changes that you anticipate occurring with respect to your financial or personal situation. \_\_\_\_\_

**ESTATE  
PLANNING  
DOCUMENT  
INFORMATION**

The person currently has a:

Will Yes  No

Trust Yes  No

Power of Attorney for finances Yes  No

Power of Attorney for health care decisions Yes  No

Gift  Inheritance  Lawsuit  Other  Approximately how much? \_\_\_\_\_



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**VETERAN'S  
SERVICE  
INFORMATION**

Veteran's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SS #: \_\_\_\_\_

City, State, and Country where Veteran was born: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Location of marriage, if applicable (city and state): \_\_\_\_\_

Location of divorce, if applicable (city and state): \_\_\_\_\_

Branch of Service: \_\_\_\_\_

Date of Service (start and end dates): \_\_\_\_\_

VA File #: \_\_\_\_\_ If Veteran is deceased, date of death: \_\_\_\_\_