



FERNANDEZ
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Date: _____

LONG TERM PLANNING QUESTIONNAIRE
CONFIDENTIAL INFORMATION

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.

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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**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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**INFORMATION
ABOUT THE
PERSON
SEEKING
SERVICES**

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:

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: _____