*The Law Office of*

# Michael J. Girardi

# Elder Care Questionnaire

## THE PERSONAL AND CONFIDENTIAL FILE

OF

_____

If you have any questions or need assistance in completing this questionnaire, please do not hesitate to call 724-339-1062. Make sure to complete this questionnaire and bring it with you to our initial meeting.

**ALL THE INFORMATION YOU PROVIDE IN THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL.**

PLEASE NOTE that no attorney-client relationship has been formed by receiving or completing this questionnaire. If you do not return your completed questionnaire within **THIRTY (30) DAYS** from the date of receipt, your file will be closed and the Law Office of Michael J. Girardi will take no further actions in this matter.

## INTRODUCTION

This initial elder care questionnaire is designed to give the Law Office of Michael J. Girardi an accurate understanding of your current situation so that we can better advise you on your elder care needs. Please be as complete as possible when answering this questionnaire; however do not delay an appointment for lack of answers to these questions. If any of the requested information does not apply or is not readily available, leave those sections blank. Feel free to attach any additional information you would like to provide us.

**PART I. PERSONAL INFORMATION**

## A. Client

Name: _____ Birth Date: ____ / ____ / _____
U.S. Citizen: _____ Yes _____ No Veteran: _____ Yes _____ No
Soc. Sec. No. _____ - _____ - _____ Date of Discharge: ____ / ____ / _____
Cell Phone: _____ Email: _____
Marital Status: _____ Date of Divorce: ____ / ____ / _____

## B. Spouse (if applicable)

Name: _____ Birth Date: ____ / ____ / _____
U.S. Citizen: _____ Yes _____ No Veteran: _____ Yes _____ No
Soc. Sec. No. _____ - _____ - _____ Date of Discharge: ____ / ____ / _____
Cell Phone: _____ Email: _____
If deceased, Date of Death: ____ / ____ / _____

## C. Residence

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Date of Marriage: ____ / ____ / _____

## D. Children& Grandchildren

Name of Child: _____ Birth Date: ____ / ____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
Marital Status: _____ Children (Y/N): _____

Name of Child: _____ Birth Date: ____ / ____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
Marital Status: _____ Children (Y/N): _____

Name of Child: _____ Birth Date: ____ / ____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
Marital Status: _____ Children (Y/N): _____

Name of Child: _____ Birth Date: ____ / ____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
Marital Status: _____ Children (Y/N): _____

Name of Child: _____ Birth Date: ____ / ____ / _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Email: _____
Marital Status: _____ Children (Y/N): _____

## Grandchildren

| Name | Parent | Birth Date |
|---|---|---|
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |
| _____ | _____ | ____ / ____ / _____ |

Are all of your children / grandchildren in good health? _____ Yes _____ No
Are any of your children / grandchildren blind? _____ Yes _____ No
Are any of your children / grandchildren disabled? _____ Yes _____ No
Are any of your children / grandchildren receiving government Benefits?
(*Such as Disability, SSI, Medicaid, or Veteran's Benefits*) _____ Yes _____ No

Do any of your children / grandchildren have problems with:

| | | | | | |
|---|---|---|---|---|---|
| Drug Addiction? | _____ Yes | _____ No | Finances | _____ Yes | _____ No |
| Alcoholism? | _____ Yes | _____ No | Creditors | _____ Yes | _____ No |
| Gambling? | _____ Yes | _____ No | | | |

Are any of your children / grandchildren in an unstable
marriage / divorce foreseeable? _____ Yes _____ No

### E. Miscellaneous

Do you have pets? _____ Yes _____ No
Does anyone live in your home with you? _____ Yes _____ No

Please rate the following, from 1 (lowest) to 10 (highest)

| | | | |
|---|---|---|---|
| Client's Mental Health | _____ | Client's Physical Health | _____ |
| Spouse's Mental Health | _____ | Spouse's Physical Health | _____ |

## PART II. CURRENT ESTATE PLAN & ADVISORS

### A. Current Estate Plan

Client, do you have any of the following:

Last Will & Testament _____ Yes _____ No
Financial / General Durable Power of Attorney _____ Yes _____ No
Health Care Power of Attorney / Living Will _____ Yes _____ No
Trust _____ Yes _____ No
Prenuptial Agreement _____ Yes _____ No

Spouse, do you have any of the following:

| | | |
|---|---|---|
| Last Will & Testament | _____ Yes | _____ No |
| Financial / General Durable Power of Attorney | _____ Yes | _____ No |
| Health Care Power of Attorney / Living Will | _____ Yes | _____ No |
| Trust | _____ Yes | _____ No |
| Prenuptial Agreement | _____ Yes | _____ No |

Do you have a safe deposit box? _____ Yes _____ No

If yes, please provide the location: _____

## B. Advisors

| Position | Name | Phone Number |
|---|---|---|
| Investment Advisor | _____ | _____ |
| Accountant | _____ | _____ |
| Life Insurance Agent | _____ | _____ |
| Other Attorney | _____ | _____ |
| Primary Physician | _____ | _____ |

## PART III. INSURANCE

### A. Life Insurance

Name of Company: _____ Policy #: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Policy: _____ Owner: _____

Insured: _____ Face Value: _____

Death Benefit: _____ Cash Value: _____

Beneficiary: _____

Name of Company: _____ Policy #: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Policy: _____ Owner: _____

Insured: _____ Face Value: _____

Death Benefit: _____ Cash Value: _____
Beneficiary: _____

Name of Company: _____ Policy #: _____
Address: _____
City: _____ State: _____ Zip: _____
Type of Policy: _____ Owner: _____
Insured: _____ Face Value: _____
Death Benefit: _____ Cash Value: _____
Beneficiary: _____
Name of Company: _____ Policy #: _____
Address: _____
City: _____ State: _____ Zip: _____
Type of Policy: _____ Owner: _____
Insured: _____ Face Value: _____
Death Benefit: _____ Cash Value: _____
Beneficiary: _____

B. Long Term Care Insurance

Name of Company: _____ Policy #: _____
Address: _____
City: _____ State: _____ Zip: _____
Type of Policy: _____ Owner: _____
Insured: _____ Is spouse insured under policy (Y/N) ____
Beneficiary: _____
Daily Rate: _____ Maximum Payment _____ Duration of Policy: _____

**PART IV GIFTS**

1. Have you ever filed a Federal Gift Tax Return? _____ Yes _____ No
   If so, for what calendar year(s)? _____

2. Have you ever made gifts in in excess of $10,000? _____ Yes _____ No

3. Have you made gifts in excess of $500 in any one month to an individual, group of individuals or trusts within the past 60 months? _____ Yes _____ No

4. Were names added to or removed from any bank, investment, or financial account held jointly with another individual in the past 60 months? _____ Yes _____ No

If yes to 2, 3 or 4 above, please list the recipients below:

| Name | Date | Amount |
|---|---|---|
| _____ | ____ / ____ / _____ | _____ |
| _____ | ____ / ____ / _____ | _____ |
| _____ | ____ / ____ / _____ | _____ |
| _____ | ____ / ____ / _____ | _____ |
| _____ | ____ / ____ / _____ | _____ |
| _____ | ____ / ____ / _____ | _____ |

**PART V HEALTH CARE (CLIENT)**

**A. Primary Physician**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

**B. Insurance**

Health Insurance Provider: _____

Policy Number / ID: _____

Is Client currently receiving benefits under PACE or PACENET? ____ Yes ____ No

If Client is a Veteran, are they receiving Tricare? ____ Yes ____ No

Does Client have a supplemental health insurance policy? ____ Yes ____ No

If yes, please list the name of the provider and monthly premium: $_____

If yes, please name company: _____

## C. Independent/ Assisted Living, Personal Care Home or Skilled Nursing Facility

Facility:_____

Address:_____

City:_____ County:_____ State:_____ Zip:_____

Telephone Number: _____

| | |
|---|---|
| Monthly Cost | $_____ |
| Monthly Prescription Cost | $_____ |
| Monthly Incontinent Cost | $_____ |
| Monthly Caregiver Cost | $_____ |
| Other | $_____ |
| Other | $_____ |
| **TOTAL MONTHLY COST** | $_____ |

Date entered facility: _____/ ____/ _____

Medicare coverage ended / will end: _____/ ____/ _____

The facility is paid through: _____/ ____/ _____

## D. Additional Care Giving Services Needed

I need assistance with the following:

| | | |
|---|---|---|
| Assistance with bathing | _____ Yes | _____ No |
| Standing and sitting | _____ Yes | _____ No |
| Getting in and out of bed | _____ Yes | _____ No |
| Eating | _____ Yes | _____ No |
| Walking | _____ Yes | _____ No |
| Dressing and undressing | _____ Yes | _____ No |
| Taking medication | _____ Yes | _____ No |

Name of Caregiver/Agency providing care: _____

How many hours per day / days per week is care received:_____

## E. Diagnosis / Prognosis

Medical Condition: _____
Prognosis: _____
Course of Treatment: _____

## PART VI. LIABILITIES

Please list any significant creditors you may have, the current balance, and whether the liability is owed solely by you or jointly with another.

| Creditor | Current Balance | Sole / Joint |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are there any legal issues we should be aware of? _____ Yes _____ No

## PART VII. ASSETS, INCOME, & EXPENSES

Please provide the value of each asset / income / expenses in the appropriate space. Pay particular attention to how the asset is owned or titled.

### A. General Assets

| ASSET | HUSBAND | WIFE | JOINT | |
|---|---|---|---|---|
| | | | w/ spouses | w/ another |
| Personal Effects | | | | |
| Jewelry | | | | |
| Furnishings & Art | | | | |
| Collectibles | | | | |
| Checking Account | | | | |
| Savings Account | | | | |
| Money Market Account | | | | |

| | | | | |
|---|---|---|---|---|
| Certificates of Deposit | | | | |
| Residence Property | | | | |
| Other Real Estate | | | | |
| Closely Held Business Ownership Interest | | | | |
| Automobiles | | | | |
| Other Vehicles | | | | |
| Stocks | | | | |
| Bonds | | | | |
| Mutual Funds | | | | |
| Annuities | | | | |
| IRA / Roth | | | | |
| 401K / 403B, etc. | | | | |
| Other | | | | |
| Other | | | | |
| Other | | | | |
| Total | | | | |

## B. Income

| MONTHLY INCOME | |
|---|---|
| **Type** | **Amount** |
| Salary/Wages | |
| Social Security Benefits | |
| Pension | |
| Retirement Benefits (Gross) | |
| Veterans Disability Income | |
| Disability | |
| Annuity Income | |
| Interest/Dividends | |
| Rental Income | |
| Other Income | |
| Medicare Part D | |
| Medicare Part B Deduction | |
| Total Income | |

## C. Expenses

| MONTHLY SHELTER EXPENSES | |
|---|---|
| Mortgage | |
| Rent | |
| Real Estate Taxes | |
| Water | |
| Sewer | |
| Gas | |
| Electric | |
| Telephone | |
| Homeowner's/Renter's Insurance | |
| Condominium Fees | |

| MONTHLY NON-SHELTER EXPENSES | |
|---|---|
| Food | |
| Health Insurance Premiums | |
| Dental Insurance Premiums | |
| Vision Insurance Premiums | |
| Clothing | |
| Automobile Insurance Premiums | |
| Home Maintenance | |
| Life Insurance Premiums | |
| Federal and State Income Taxes | |
| Cable TV | |

| OTHER RECURRING EXPENSES (NOT NOTED ABOVE) | |
|---|---|
| | |
| | |
| | |
| | |

| | |
|---|---|
| | |

## C. Miscellaneous

Do you own any firearms? _____ Yes _____ No

Do you anticipate a large inheritance? _____ Yes _____ No

## Certification

The undersigned hereby represent to the Law Office of Michael J. Girardi that the information contained in this questionnaire is accurate and complete, and that the undersigned understand that the Law Office will rely on this information. We understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the Law Office may not be appropriate.

_____ _____

Signature of Client or Client Representative Date