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. Former 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)
Your Mental Health _____ Your Physical Health_____

PART II. CURRENT ESTATE PLAN & ADVISORS

A. Current Estate Plan

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

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	OWNED INDIVIDUALLY	OWNED JOINTLY WITH 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