

LONG-TERM CARE PLANNING FACT-FINDER

Initial Contact Date _____

Referred by: _____ Address _____ Phone _____

Have you looked at LTCI before?

Why didn't you buy? _____

Do you know anyone that has needed long-term care? _____

Do you believe that you (or your spouse) could need daily help at some time in the future? _____

If so, where would you want to be cared for? _____

Have you ever seen a private assisted living center or a small adult care home? _____

Do you understand that Medicare only pays for a maximum of 100 days for skilled nursing care? _____

Do you understand the requirements and limitations of receiving care under the Medi-Cal Program? _____

Where do you think you will live when you retire or become older, geographically? _____

Do you know what the average cost of care is today in that area? _____

Will you have sufficient assets and income to pay for 2,3,4 or more years of care which can cost \$50,000 a year now, or \$100,000 per year about 15 years from now? Yes ___ No ___ I Don't Know _____

If you will not have enough money, do you have children or other family who will help you financially?

Yes ___ No _____

If setting appointment – does client want family member or friend to be present?

Not Interested: _____

Why? _____

FACT FINDER

PERSONAL AND FAMILY INFORMATION

Client(s) Full Name(s): _____

Address: _____

Phone (home) _____ (work) C- _____ /S- _____ (Fax) _____

E-mail: Client _____ Spouse _____

Child _____ Married _____ # Children _____ Location _____

Child _____ Married _____ # Children _____ Location _____

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Child _____ Married _____ # Children _____ Location _____

Child _____ Married _____ # Children _____ Location _____

Child _____ Married _____ # Children _____ Location _____

Which children help in making decisions? _____

If you needed care, which children or grandchildren would be available on a regular daily basis to help? _____

Would you live with any of your children? _____

Do they have careers or could they be your full-time caregivers? _____

Client #1 _____

DOB ____/____/____ Age ____ Height ____ Weight ____

Social Security# ____ - ____ - ____ Drivers License# _____

Employer _____ Occupation _____ Retired _____

Client #2

DOB _____ Age ____ Height ____ Weight ____

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____ Retired _____

Professional Associations _____

Clubs or Organizations _____

Hobbies or Interests _____

Volunteer Activities _____

Religious Affiliation _____ House of Worship _____

Do you have plans to move out of the state, country?

If so, where?

Do you know the cost of LTC there?

MEDICAL INFORMATION

During the past 5 years, have you used tobacco? ____ Yes ____ No

Are you receiving Disability? ____ Yes ____ No

What For? _____ How Long? _____

Are you receiving health care services through the Medi-Cal Program? ___ Yes ___ No

Have you ever been declined insurance? _____

Overall Health condition: _____

In the last 10 years, have you been diagnosed or treated for any of the following or anything else?

- | | | |
|-----------------------------------|----------------|----------------|
| AIDS | Yes ___ No ___ | Comments _____ |
| Cancer | Yes ___ No ___ | Comments _____ |
| Benign tumor | Yes ___ No ___ | Comments _____ |
| Immune System disorder | Yes ___ No ___ | Comments _____ |
| Lupus | Yes ___ No ___ | Comments _____ |
| Any blood related diseases | Yes ___ No ___ | Comments _____ |
| Arrythmia | Yes ___ No ___ | Comments _____ |
| Atrial Fibrillation | Yes ___ No ___ | Comments _____ |
| Pacemaker | Yes ___ No ___ | Comments _____ |
| High Blood Pressure | Yes ___ No ___ | Comments _____ |
| Other Heart Disease | Yes ___ No ___ | Comments _____ |
| Angioplasty or other procedure | Yes ___ No ___ | Comments _____ |
| Stroke | Yes ___ No ___ | Comments _____ |
| TIA's (Mini strokes) | Yes ___ No ___ | Comments _____ |
| Diabetes | Yes ___ No ___ | Comments _____ |
| Take Insulin or oral medication | | |
| Neuropathy (related to diabetes) | Yes ___ No ___ | Comments _____ |
| Lung or respiratory disorder | Yes ___ No ___ | Comments _____ |
| Asthma (chronic or seasonal) | Yes ___ No ___ | Comments _____ |
| Thyroid disease | Yes ___ No ___ | Comments _____ |
| Stomach disorder | Yes ___ No ___ | Comments _____ |
| Digestive problems | Yes ___ No ___ | Comments _____ |
| Bladder or prostate problems | Yes ___ No ___ | Comments _____ |
| Kidney problems | Yes ___ No ___ | Comments _____ |
| Arthritis, osteo or rheumatoid | Yes ___ No ___ | Comments _____ |
| Osteoporosis | Yes ___ No ___ | Comments _____ |
| Any falls resulting in injury | Yes ___ No ___ | Comments _____ |
| Fractures or broken bones | Yes ___ No ___ | Comments _____ |
| Joint replacement | Yes ___ No ___ | Comments _____ |
| Fibromyalgia | Yes ___ No ___ | Comments _____ |
| Spine, joints, muscles problems | Yes ___ No ___ | Comments _____ |
| Chronic Pain condition | Yes ___ No ___ | Comments _____ |
| Chronic Fatigue | Yes ___ No ___ | Comments _____ |
| Problems with balance | Yes ___ No ___ | Comments _____ |
| Epilepsy or Seizures | Yes ___ No ___ | Comments _____ |
| Parkinson's disease | Yes ___ No ___ | Comments _____ |
| Multiple Sclerosis | Yes ___ No ___ | Comments _____ |
| Lou Gehrig's disease | Yes ___ No ___ | Comments _____ |
| Alzheimer' s or other Dementia | Yes ___ No ___ | Comments _____ |
| Any Neurological Problem | Yes ___ No ___ | Comments _____ |
| Depression or Anxiety | Yes ___ No ___ | Comments _____ |
| Psychiatric disorder | Yes ___ No ___ | Comments _____ |
| Any memory problems | Yes ___ No ___ | Comments _____ |
| Alcoholism or drug abuse | Yes ___ No ___ | Comments _____ |

Glaucoma	Yes ___ No ___	Comments _____
Macular degeneration	Yes ___ No ___	Comments _____
Other eye disease	Yes ___ No ___	Comments _____
Hearing problems	Yes ___ No ___	Comments _____
Speech problems	Yes ___ No ___	Comments _____
Anything else?		

Any Surgeries-Past 10 years

If yes to any of the above, when, what treatment, what prognosis, date of last treatment, etc.

Medications:

What are you taking, what for, what dose, for how long, has it worked?

Physician Visits in the past 5 years

Have you complained to the doctor of any memory problems? Yes ___ No ___ If so, when, why?

Have you repeatedly complained to the doctor of any specific problem? Yes ___ No ___ If so, when, why?

Have you repeatedly complained to the doctor of any joint pain? Yes ___ No ___ If so, when, why?

Have you complained to the doctor about being depressed or anxious? Yes ___ No ___ If so, when, why?

In the past 3 years, any special tests, x-rays, etc. Yes ___ No ___ If so, when, why?

In the past 3 years, have you had physical therapy? Yes ___ No ___ If so, when, why?

Hospitalizations or ER visits in the last 10 years? Yes ___ No ___ If so, when, why?

Do You Have Any Physical Limitations or need any help on a day to day basis? Yes ___ No ___

Have you used a cane, walker, or wheelchair in the past 5 years? Yes ___ No ___ If so, when, why?

How much wine, beer, or liquor do you drink on any one occasion? _____

How often do you drink enough alcohol to be considered legally intoxicated - 0.08% blood alcohol ?

Frequently _____ Occasionally _____ Never _____
Do you fly in a private airplane or do you fly as a non-fare paying passenger on commercial planes?
Yes _____ NO _____

Physician Information: Last 5 years

Name _____ Address _____ Phone _____

Primary Care _____

Primary Care _____

Health Insurance Information

Health insurance Plan _____ HMO _____ PPO _____ Indemnity _____

Medicare: Yes ___ No ___ Medigap. Plan Type _____ Carrier _____ Monthly Cost: \$ _____

Critical Illness Insurance _____

Coverage For _____ Coverage Amount \$ _____ Annual Premium \$ _____

Accident Insurance _____

Coverage For _____ Coverage Amount \$ _____ Annual Premium \$ _____

Activity Level

What do you do for physical activity? _____

Do you drive a Car? Yes ___ No ___ If so, how many hours a week? _____

Do you spend at least 20 hours a week out of your house? Yes ___ No ___ If so, what do you do? _____

What other activities do you do on a regular weekly basis? _____

Family Health & Longevity History

Father: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

Mother: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

G-Father 1: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

G-Father 2: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

G-Mother 1: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

G-Mother 2: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

Sibling: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

Sibling: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

Sibling: Living ___ Age ___ Deceased ___ Age at Death ___ Any significant illness during lifetime? _____

Sibling: Living____Age____Deceased____Age at Death____Any significant illness during lifetime?
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Any of the above need LTC?

Any other significant family information?

Financial Information

Current Income Sources

What is your annual after-tax income from work?

Client: \$_____ Spouse \$_____

What is your annual income from liquid investments (Stocks, Bonds, Mutual Funds, CD's, etc.?)

Client: \$_____ Spouse \$_____

Or Joint Investment Income \$_____

What is you annual income from non-liquid assets such as real estate, business ownership, etc.?)

Client: \$_____ Spouse \$_____

Or Joint hard asset Income \$_____

Do you have additional income from other sources such as inheritances, annuities, private loans, etc.?)

Client: \$_____ Spouse \$_____

Or Joint Income \$_____

Future Income Sources

Do you have a pension? How much annual income do you expect to receive during your later years?

Client: \$_____ Spouse \$_____

Or Joint retirement Income \$_____

If one of you dies before the other, how will your income change to the remaining spouse?

Client: \$_____ Spouse \$_____

Assets

Do you own your own home? Current Value: \$_____ Amount of Equity \$_____

Net Value of other real estate holdings? \$_____

Net Value of any Business ownership? \$_____

What is the current value of your:

401K's \$_____

IRA's \$_____

Annuities \$_____

Stocks, Bonds, Mutual Funds \$_____

Money Market or CD's \$_____

Cash Value Life Insurance \$ _____
Art, Jewelry, Collectibles \$ _____
Any other assets \$ _____

Are you an aggressive, moderate, or conservative investor? _____
What rate of return (before taxes) do you **conservatively** expect to get in your later years? _____ %

Life insurance? What type _____ Death benefit \$ _____ Do you still need it?
Client: _____ \$ _____ Yes ___ No ___
Spouse _____ \$ _____ Yes ___ No ___

Annuities? What Type _____ How much \$ _____ Annuitized:?
Client: _____ \$ _____ Yes ___ No ___
Spouse: _____ \$ _____ Yes ___ No ___

Wedding Date: Month _____ Day _____ Year _____

If you are re-married, do you have a pre-nuptial agreement maintaining separate assets? Yes ___ No ___

Are there any other dependents you are helping to support? Yes ___ No ___ \$ _____ Monthly
Is there a possibility of any other people, perhaps a parent, who might become financially dependent upon you? Yes ___ No ___

Anything else that I should know about you to help me in designing a plan for LTC Insurance? Would you want to co-insure, want full coverage, etc.? _____

Do you have a Living Trust? Yes ___ No ___ When was it last updated? _____

Do you have a Pre-arranged Funeral Plan? _____

Professional Advisor Information

Attorney _____	Address _____	Phone _____
Accountant _____	Address _____	Phone _____
Fin/Planner _____	Address _____	Phone _____
Insur.Agent _____	Address _____	Phone _____

Can we contact them to let them know the policy information for their records?

Who Do You Know I Can Help Educate?

What organizations or clubs do you belong to that would benefit from a speaker about long-term care planning? _____

Do they have friends or family members who could benefit from getting LTCI?
Names & Phone Numbers: _____

