

## 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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?**

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

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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 Sibling: Living \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Age at Death \_\_\_\_\_ Any significant illness during lifetime?

**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 your 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_