SERVING FAMILIES IN GEORGIA AND TENNESSEE
ELDER LAW
PRACTICE OF DAVID L. MCGUFFEY
Connecting Health, Wealth and Peace of Mind

EIN NO: 55-0819817

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Basic Legal-Financial Review

This questionnaire helps us help you. Complete as much or as little as you like, but keep in mind that we cannot help you identify and resolve problems if we don't know about them. Use additional pages as necessary. The information you give us will be kept confidential.

1. Personal Information

Full Name: ______________________________

Address: ______________________________

____

Birth Date: ______________________________

Social Security #: ______________________________

U.S. Citizen: Yes ☐ No ☐

Veteran: Yes ☐ No ☐

Are you residing at home? Yes ☐ No ☐

2. Spouse Information *(Complete if applicable)*

Are you Married? Yes ☐ No ☐ Widow/Widower ☐

If deceased, date of death: ______________________________

Spouse's Name: ______________________________

Address: ______________________________

____

Birth Date: ______________________________

Social Security #: ______________________________

U.S. Citizen: Yes ☐ No ☐

Veteran: Yes ☐ No ☐

Is your spouse residing at home? Yes ☐ No ☐

3. **Children** *(complete if applicable)*

Name	Address	Phone #	Age

Are all of your children in good health Yes ☐ No ☐
Are any of your children disabled? Yes ☐ No ☐
Are any of your children receiving SSI? Yes ☐ No ☐
Are any of your children receiving Medicaid Yes ☐ No ☐
Do any of your children reside in your home? Yes ☐ No ☐
Do you have any grandchildren with special needs that you want to plan for? Yes ☐ No ☐

4. **Medical Information**

Are you worried about paying for health care? Yes ☐ No ☐

Do you have any chronic health care problems?: Yes ☐ No ☐

Does your spouse have any chronic health care problems?: Yes ☐ No ☐

Diagnosis: ____

Do you have unmet needs?______________________________________

If so, what are they?:____

5. **Where are you now?**

You	Spouse	Where
☐	☐	Home
☐	☐	Living with family
☐	☐	Assisted-living facility
☐	☐	Nursing Home
☐	☐	Other:______________________________

6. Monthly Income

Sections 6 through 11 are designed to help us evaluate a number of issues, including your ability to live independently, your spending patterns if you have concerns about running out of money and your eligibility for public benefits.

	Your Income	**Spouse's Income**
Social Security (Gross)	____________________	____________________
Retirement income (Gross)	____________________	____________________
VA Disability	____________________	____________________
Annuity Income	____________________	____________________
Rental Income	____________________	____________________
Other Income	____________________	____________________
Total Monthly Income	____________________	____________________

If you are unsure about other income, or if there is irregular income, describe it here:

____

7. Monthly Cost of Medical Care

	Your Expenses	**Spouse's Expenses**
Monthly cost of care	____________________	____________________
Prescriptions	____________________	____________________
Incidental care costs	____________________	____________________
Other health expenses	____________________	____________________
Total Health Expenses	____________________	____________________

8. Monthly Shelter Expenses

Rent/Mortgage	____________________
Real Estate Taxes	____________________
Water	____________________
Sewer	____________________
Utilities	____________________
Condominium Fees	____________________

Total Shelter Expenses ____________________

9. Monthly Non-Shelter Expenses

Food	____________________
Clothing	____________________
Telephone	____________________
Transportation	____________________
Home Maintenance	____________________
Life Insurance Premiums	____________________
Health Insurance Premiums	____________________
Cable TV	____________________
Income Taxes	____________________
Other:________________	____________________
Other:________________	____________________
Other:________________	____________________
Other:________________	____________________
Total Non-Shelter Expenses	____________________

10. Health and Long-Term Care Insurance

Do you have ...	You	Spouse
Private Health Insurance	☐ Yes ☐ No	☐ Yes ☐ No
Medicare	☐ Yes ☐ No	☐ Yes ☐ No
Medicare Supplement	☐ Yes ☐ No	☐ Yes ☐ No
Long-Term Care Insurance	☐ Yes ☐ No	☐ Yes ☐ No

11. Assets/Liabilities

Asset	Asset	Liability
Home	____________________	____________________
Automobile	____________________	____________________
Checking Accounts	____________________	____________________
Savings Accounts	____________________	____________________
Money Market Accounts	____________________	____________________
Certificates of Deposit	____________________	____________________

Mutual Funds	______________________	______________________
Stocks	______________________	______________________
Bonds	______________________	______________________
Annuities	______________________	______________________
401(k)	______________________	______________________
IRA	______________________	______________________
Other Real Estate	______________________	______________________
Other:________________	______________________	______________________
Other:________________	______________________	______________________
Total	______________________	______________________

12. Life Insurance

Life Insurance is treated as an asset under most public benefits programs. More than any other asset, life policies tend to cause unexpected eligibility problems. If you have any life insurance policies, please tell us about them.

Company Name:____
Address:____
Face Value:_____________ Cash Value: _______________ Death Value: ____________
Owner:____________________________ Beneficiary: __________________________

Company Name:____
Address:____
Face Value:_____________ Cash Value: _______________ Death Value: ____________
Owner:____________________________ Beneficiary: __________________________

Company Name:____
Address:____
Face Value:_____________ Cash Value: _______________ Death Value: ____________
Owner:____________________________ Beneficiary: __________________________

Company Name:____
Address:____
Face Value:_____________ Cash Value: _______________ Death Value: ____________
Owner:____________________________ Beneficiary: __________________________

13. Gifts

(If you have made any gifts in the last 60 months, please complete this section)

Recipient Name	Date	Amount
______________________	______________________	______________________

______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Have you ever filed a Federal Gift Tax Return?: Yes ☐ No ☐

14. Prior Estate Planning

Do you have a …	You	Spouse
Durable Power of Attorney	☐ Yes ☐ Need	☐ Yes ☐ Need
Health Care Power of Attorney	☐ Yes ☐ Need	☐ Yes ☐ Need
Living Will	☐ Yes ☐ Need	☐ Yes ☐ Need
Will	☐ Yes ☐ Need	☐ Yes ☐ Need
Revocable Living Trust	☐ Yes ☐ Need	☐ Yes ☐ Need
Other Trust	☐ Yes ☐ Need	☐ Yes ☐ Need
Family LLC, Partnership or corporation	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to any of the above, please provide us with copies of your existing estate planning documents.

15. Other

If you have any other concerns, write them here or on additional pages:

____

____

____

The information written above is true and correct to the best of my knowledge and the Elder Law Practice of David L. McGuffey may rely on this information in planning for me, my spouse and my dependents.

______________________________ ______________________

Signature Date

______________________________ ______________________

Signature Date