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_____________________________

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?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>AIDS</td>
<td></td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Benign tumor</td>
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<tr>
<td>Immune System disorder</td>
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<tr>
<td>Lupus</td>
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<tr>
<td>Any blood related diseases</td>
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<tr>
<td>Arrhythmia</td>
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<tr>
<td>Atrial Fibrillation</td>
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<tr>
<td>Pacemaker</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Other Heart Disease</td>
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<tr>
<td>Angioplasty or other procedure</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>TIA’s (Mini strokes)</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Take Insulin or oral medication</td>
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<tr>
<td>Neuropathy (related to diabetes)</td>
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<tr>
<td>Lung or respiratory disorder</td>
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<tr>
<td>Asthma (chronic or seasonal)</td>
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<tr>
<td>Thyroid disease</td>
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<tr>
<td>Stomach disorder</td>
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<tr>
<td>Digestive problems</td>
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<td>Bladder or prostate problems</td>
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<tr>
<td>Kidney problems</td>
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<td>Arthritis, osteo or rheumatoid</td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td>Any falls resulting in injury</td>
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<tr>
<td>Fractures or broken bones</td>
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<tr>
<td>Joint replacement</td>
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<tr>
<td>Fibromyalgia</td>
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<td>Spine, joints, muscles problems</td>
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<tr>
<td>Chronic Pain condition</td>
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<td>Chronic Fatigue</td>
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<tr>
<td>Problems with balance</td>
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<tr>
<td>Epilepsy or Seizures</td>
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<tr>
<td>Parkinson’s disease</td>
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<tr>
<td>Multiple Sclerosis</td>
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<tr>
<td>Lou Gehrig’s disease</td>
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<tr>
<td>Alzheimer’s or other Dementia</td>
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<tr>
<td>Any Neurological Problem</td>
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<tr>
<td>Depression or Anxiety</td>
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<tr>
<td>Psychiatric disorder</td>
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<tr>
<td>Any memory problems</td>
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<tr>
<td>Alcoholism or drug abuse</td>
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</tbody>
</table>
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?
__________________ ________________________________________________________
Sibling: Living_____Age_____Deceased_____Age at Death_____Any significant illness during lifetime?
________________________________________________________________________
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:
__________________ ____________________________________________
__________________ ____________________________________________
__________________ ____________________________________________
__________________ ____________________________________________