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?____

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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_____________________________
Child________________Married_____# Children_____Location_____________________________
Child________________Married_____# Children_____Location_____________________________
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

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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:____
____
____
____

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

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 Fibrilation 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______________________________________

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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, been, 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 ?

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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?
____

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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 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 $____________________

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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:____
____
____
____
____
____

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