Daniel P. Seink Co., Ltd.
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Long-Term Care Planning: Client Information Questionnaire (Married/Short)

Personal Information (Self):

Name: _____ DOB: _____

Address: _____

_____

Mailing Address (if different): _____

_____

County: _____ U.S. Citizen? YES NO U.S. Veteran? YES NO

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Marriage: _____ Place of Marriage: _____

Personal Information (Spouse):

Name: _____ DOB: _____

Address (if different): _____

_____

Phone (if different): _____ Email: _____

U.S. Citizen? YES NO U.S. Veteran? YES NO Wartime Veteran? YES NO

Primary Contact Information:

Name: _____ Phone: _____

Mailing Address: _____

_____

Email: _____ Relationship to Client: _____

Children (Related by blood or legal adoption):

Name: _____ Age: _____

Mailing Address: _____

_____

Phone: _____ Email: _____

Relationship to Clients (Please check):

Self: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): _____

Spouse: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): _____

Name of Child's Spouse (if applicable): _____

Children's names/ages (if applicable): _____

_____

Is this child receiving Supplement Security Income (SSI), Social Security Disability (SSD), or is blind or has any disabilities? YES NO

May we speak with this child if needed? YES NO

Name: ______________________________ Age: __________________________

Mailing Address: ____

____

Phone: ________________________ Email: ____________________________________

Relationship to Clients (Please check):

Self: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): ___________

Spouse: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): ___________

Name of Child's Spouse (if applicable): _____________________________

Children's names/ages (if applicable): ____

____

Is this child receiving Supplement Security Income (SSI), Social Security Disability (SSD), or is blind or has any disabilities? YES NO

May we speak with this child if needed? YES NO

Name: ______________________________ Age: __________________________

Mailing Address: ____

____

Phone: ________________________ Email: ____________________________________

Relationship to Clients (Please check):

Self: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): ___________

Spouse: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): ___________

Name of Child's Spouse (if applicable): _____________________________

Children's names/ages (if applicable): ____

____

Is this child receiving Supplement Security Income (SSI), Social Security Disability (SSD), or is blind or has any disabilities? YES NO

May we speak with this child if needed? YES NO

Name: ______________________________ Age: __________________________

Mailing Address: ____

____

Phone: ________________________ Email: ____________________________________

Relationship to Clients (Please check):

Self: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): ___________

Spouse: Natural child: _____ Adopted: _____ Step-child: _____ Other (please specify): ___________

Name of Child's Spouse (if applicable): _____________________________

Children's names/ages (if applicable): ____

____

Is this child receiving Supplement Security Income (SSI), Social Security Disability (SSD), or is blind or has any disabilities? YES NO

May we speak with this child if needed? YES NO

Health-Related Information (self):

Briefly describe your current physical health status and indicate diagnosed conditions or diseases: _____

_____

Briefly describe your current mental health status and indicate diagnosed conditions or diseases: _____

_____

What prescriptions are you currently taking? _____

_____

Have you stayed in a hospital or nursing home within the last 30 days? YES NO

Do you need help with any of the following activities?

Bathing: YES NO	Transferring from bed to chair: YES NO	Dressing: YES NO
Walking: YES NO	Feeding yourself: YES NO	Using the toilet: YES NO
Doing laundry: YES NO	Using the telephone: YES NO	Taking medications: YES NO
Managing money: YES NO		

Health-Related Information (spouse):

Briefly describe your spouses current physical health status and indicate diagnosed conditions or diseases: _____

_____

Briefly describe your spouses current mental health status and indicate diagnosed conditions or diseases: _____

_____

What prescriptions are your spouse currently taking? _____

_____

Have you stayed in a hospital or nursing home within the last 30 days? YES NO

Does your spouse need help with any of the following activities?

Bathing: YES NO	Transferring from bed to chair: YES NO	Dressing: YES NO
Walking: YES NO	Feeding yourself: YES NO	Using the toilet: YES NO
Doing laundry: YES NO	Using the telephone: YES NO	Taking medications: YES NO
Managing money: YES NO		

Place where you live (please check the correct boxes and specify how long you have lived there):

Single-family home or apartment:

Self: ☐ Since: _____ Spouse: ☐ Since: _____

Same, but you need assistance:

Self: ☐ Since: _____ Spouse: ☐ Since: _____

Retirement living community:

Self: ☐ Since: _____ Spouse: ☐ Since: _____

Assisted-living facility:

Self: ☐ Since: _____ Spouse: ☐ Since: _____

Nursing home:

Self: ☐ Since: _____ Spouse: ☐ Since: _____

Other (please specify: _____

Self: ☐ Since: _____ Spouse: ☐ Since: _____

County of residence:

Self: ☐ Since: _____ Spouse: ☐ Since: _____

Estate Planning (Self):

Revocable Trust:
Date Signed: _____ Trustee: _____ Alternate: _____

Irrevocable Trust:
Date Signed: _____ Trustee: _____ Alternate: _____

Last Will and Testament:
Date Signed: _____ Executor: _____ Alternate: _____

General Durable Power of Attorney:
Date Signed: _____ Agent: _____ Alternate: _____

Health Care Power of Attorney:
Date Signed: _____ Agent: _____ Alternate: _____

Living Will:
Date Signed: _____ Agent: _____ Alternate: _____

Premarital Agreement:
Date Signed: _____ State: _____

Estate Planning (Spouse):

Revocable Trust:
Date Signed: _____ Trustee: _____ Alternate: _____

Irrevocable Trust:
Date Signed: _____ Trustee: _____ Alternate: _____

Last Will and Testament:
Date Signed: _____ Executor: _____ Alternate: _____

General Durable Power of Attorney:
Date Signed: _____ Agent: _____ Alternate: _____

Health Care Power of Attorney:
Date Signed: _____ Agent: _____ Alternate: _____

Living Will:
Date Signed: _____ Agent: _____ Alternate: _____

Premarital Agreement:
Date Signed: _____ State: _____

Assets:

Real Estate (including residence and any other real estate property):

Address:	Title Owners:	Original Cost:	Amount Owed:	Market Value:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Bank and Credit Union Accounts (including checking, savings, etc.; not IRAs)

Type of Account:	Name(s):	Financial Institution:	Approx. Value:

Stocks and Bonds (held by you):

Name of Stock/Bond:	Owners:	# of Shares/Bonds:	Cost Basis:	Approx. Value:

Stocks/Bonds/Mutual Funds (held by brokerage):

Brokerage/Mutual Co.:	Owners:	# of Shares/Bonds:	Cost Basis:	Approx. Value:

Annuities (tax deferred, not IRAs):

Company:	Owner/Insured:	Date Opened:	Cost Basis:	Approx. Value:

Retirement Plans (IRAs, 401K, 403B, etc.):

Type of Account:	Name(s):	Financial Institution:	Approx. Value:

Promissory Notes/Mortgage Deeds/Leases (money owed to you):

Note/Deed/Lease:	Person Owed $:	Original Amount:	Payment:	Balance Due:

Life Insurance (include employer-provided life insurance):

Name of Company:	Owner/Insured:	Premium:	Perm/Term:	Cash Value:	Death Benefit:

Vehicles (include boats, campers, trailers, motorcycles, etc.):

Make:	Model:	Year:	Owed:	Approx. Value:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Other/Miscellaneous (please describe): _____

_____

_____

Monthly Income:

Social Security (net figure amount deposited into bank): $_____

SSI/SSD: Name on Check: _____ Amount: $_____

Name on Check: _____ Amount: $_____

Veteran Benefits: Name on Check: _____ Amount: $_____

Name on Check: _____ Amount: $_____

Employment: Name on Check: _____ Amount: $_____

Name on Check: _____ Amount: $_____

Pension:

Employer: _____ Name on Check: _____ Amount: $_____

Employer: _____ Name on Check: _____ Amount: $_____

Employer: _____ Name on Check: _____ Amount: $_____

Employer: _____ Name on Check: _____ Amount: $_____

Annuities:

Company: _____ Name on Check: _____ Amount: $_____

Company: _____ Name on Check: _____ Amount: $_____

Company: _____ Name on Check: _____ Amount: $_____

Company: _____ Name on Check: _____ Amount: $_____

Other (rents, notes, reverse mortgage, etc.):

Source: _____ Name on Check: _____ Amount: $_____

Source: _____ Name on Check: _____ Amount: $_____

Source: _____ Name on Check: _____ Amount: $_____

Liabilities (mortgages, loans, credit card debts, notes to banks and others, unpaid medical bills, etc.):

Type of Liability:	To Whom Owed:	Present Balance:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Gifts (within the past 5 years):

Type of Asset:	To Whom Transferred:	Date Transferred:	Amount of Transfer:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Insurance/Long-Term Care Insurance Information (Self):

Medicare: Part A: _____ Part B: _____ Part C: _____ Part D: _____

Company: _____ Premium: _____

Medicare Supplement (MediGap):

Company: _____ Premium: _____

Long-Term Care Insurance:

Company: _____ Premium: _____

Other Health Insurance:

Company: _____ Premium: _____

Prescription Drug Coverage:

Company: _____ Premium: _____

Health Insurance/Long-Term Care Insurance Information (Spouse):

Medicare: Part A: _____ Part B: _____ Part C: _____ Part D: _____

Company: _____ Premium: _____

Medicare Supplement (MediGap):

Company: _____ Premium: _____

Long-Term Care Insurance:

Company: _____ Premium: _____

Other Health Insurance:

Company: _____ Premium: _____

Prescription Drug Coverage:

Company: _____ Premium: _____

Funeral/Burial Agreements:

Have pre-paid arrangements been made with a funeral home? Self: YES NO Spouse: YES NO

Have the arrangements been paid for in full or in part? IN FULL IN PART

Is the contract: Self: REVOCABLE IRREVOCABLE Spouse: REVOCABLE IRREVOCABLE

Do you currently own burial plots? Self: YES NO Spouse: YES NO

Is cremation desired? Self: YES NO Spouse: YES NO

Other/Miscellaneous Information:

Tax returns have been filed with the IRS for the past _____ out of the last three years.

Do you have any other legal issues that we should know about? If so, please describe them. _____

_____

_____

Where you referred to this office by anyone? If so, who? _____

If not, how did you find us? _____

What made you choose our firm? _____

What is the primary purpose of your visit? _____

_____

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The undersigned, being the person(s) who completed this Questionnaire, certify that the responses are accurate and complete to the best of my (our) knowledge, having made best efforts to obtain and confirm the information, and understand that it is my (our) obligation to notify Daniel P. Seink Co., Ltd. promptly if any information is subsequently discovered to be inaccurate or incomplete, and I (we) hereby release Daniel P. Seink Co., Ltd. of any liability related to inaccurate or omitted information, intending this release to be binding on my (our) heirs and beneficiaries.

Signature: _____
Name (please print): _____
Date: _____

Signature: _____
Name (please print): _____
Date: _____