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

Personal Information:

Name:_____ DOB: _____

Address: _____

_____

Mailing Address (if different):_____

_____

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

Home Phone: _____ Cell Phone: _____

Email: _____

Spousal Information (If applicable):

Name: _____ DOB: _____

Date of Death: _____ OR Date of Divorce: _____

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 Client (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 Client (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 Client (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 Client (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:
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		

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

Single-family home or apartment: ☐ Since: _____

Same, but you need assistance: ☐ Since: _____

Retirement living community: ☐ Since: _____

Assisted-living facility: ☐ Since: _____

Nursing home: ☐ Since: _____

Other (please specify: _____ ☐ Since: _____

County of residence: _____

Estate Planning:

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:

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? YES NO
Have the arrangements been paid for in full or in part? IN FULL IN PART
Is the contract: REVOCABLE IRREVOCABLE
Do you currently own burial plots? YES NO
Is cremation desired? 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: _____