LAW OFFICES OF GARY CORNICK, LLC
210 East Main Street, Somerville, NJ 08876 • (908) 253-0404
7-G Auer Court, East Brunswick, NJ 08816 • (732) 729-4700

ELDER AND DISABILITY LAW PLANNING QUESTIONNAIRE (Single)

Date _____ Tel. Home _____ Tel. Bus. _____

PART A: PERSONAL INFORMATION

CLIENT

Full Name _____ Address _____

a/k/a_____ _____Zip_____

U.S. Citizen? Yes _____ No _____ Birth Date _____

Last 4 of Social Security Number: XXX-XX-_____

If widowed, please list date of death of spouse:

Name of Primary Physician _____

Address of Primary Physician _____

CHILDREN

Are any of your children blind? Yes __ No

Are any of your children disabled? Yes __ No

Do any of your children live with you in your home? Yes __ No

SIBLING

Does a sibling live in your home with you? Yes __ No

PART B: MISCELLANEOUS INFORMATION

Age _____

If you are in a nursing home or are concerned about entering a nursing home, please list the following:

Diagnosis _____

Prognosis _____

Course of Treatment _____

If you are already in a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis:

_____

_____

PART C: MONTHLY INCOME

Client's Monthly Income	$_____
Gross Salary or Wages	$_____
Social Security Benefits (include $42.50 Medicare Part B Deduction, if applicable)	$ _____
Retirement Benefits	$ _____
Interest	$ _____
Dividends	$ _____
Other	$_____
TOTAL INCOME	$_____

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance or any other reason.

Gross Amount: $_____ (include all deductions)

Could this pension amount increase in the future? Yes_____ No_____

Are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program)? Yes _____ No _____

PART D: GIFTS

(Gifts made in excess of $1,000/year to an individual other than your spouse within the past 60 months)

Recipient_____ Date_____ Amount $_____

Recipient_____ Date_____ Amount $_____

Recipient_____ Date_____ Amount $_____

PART E: ASSETS

Please insert the approximate value of each asset/liability in the appropriate space.

ASSETS	CLIENT	LIABILITIES
PERSONAL EFFECTS		
BUSINESS INTERESTS		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
SAVINGS CERTIFICATE		
RESIDENCE (ASSESSED VALUE) BLOCK#_____ LOT#_____ (Obtain from Tax Bill)		
AUTOMOBILE(S)		
OTHER REAL ESTATE		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INS		
IRA		
NURSING HOME DEPOSIT		
OTHER		
TOTALS		

If any of your accounts are **joint with children**, please so indicate. If the account is "**or**", indicating with **one asterisk**. If the account is "**and**", indicate with **two asterisks**.

Address of any real property other than personal residence:

Street _____ City _____ State_____ Zip_____
Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

Street _____ City _____ State_____ Zip_____
Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

What did you pay for your current home including any improvements?

$_____

Name of Homeowner's Insurance Company: _____

Address: _____

Phone #: _____

PART F: LIFE INSURANCE

COMPANY (include Address and Policy Number)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFI-CIARY

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

(Include the cash value of the Life Insurance on the Life Insurance line in Part E above)

PART G: MONTHLY COST OF NURSING HOME

$_____ Cost Per Month

$_____ Prescription Cost per Month

$_____ Incontinent Cost per Month

$_____ Other per Month

$_____ **Monthly Total**

The nursing home is paid through the month of _____.

PART H: CHILDREN

CHILDREN'S NAMES	ADDRESS WITH ZIP CODE	TELEPHONE NUMBER	DATE OF BIRTH

PART I: GRANDCHILDREN

CHILDREN'S NAMES	ADDRESS WITH ZIP CODE	TELEPHONE NUMBER	DATE OF BIRTH

PART J: REFERRAL

By Whom Were You Referred to This Office?

Name _____

Address _____

PART K: SIGNATURE

The undersigned hereby represents to the Law Offices of Gary Cornick, LLC, and each of its attorneys, that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information which I am furnishing, but will **not** independently verify its accuracy. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

_____