



Law Offices of  
Gary Cornick, LLC

LAW OFFICES OF GARY CORNICK, LLC  
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**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:

\_\_\_\_\_