LAW OFFICES OF GARY CORNICK, LLC

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ELDER LAW
PLANNING QUESTIONNAIRE
(Married)

Date _____ Tel. Home _____ Tel. Bus. _____

PART A: PERSONAL INFORMATION

CLIENT HUSBAND

Full Name _____ Address _____

a/k/a_____ _____Zip_____

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

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

Name of Primary Physician _____

Address of Primary Physician _____

CLIENT WIFE

Full Name _____ Address _____

a/k/a_____ _____Zip_____

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

Social Security Number _____

Name of Primary Physician _____

Address of Primary Physician _____

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

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

PART B: MISCELLANEOUS INFORMATION

Age of Husband _____

Age of Wife _____

If either spouse is in a nursing home or contemplates entering a nursing home, please list the following:

Name of Ill Spouse_____

Diagnosis _____

Prognosis _____

Course of Treatment _____

Name of Well Spouse _____

Health of Well Spouse _____

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis:

_____

_____

PART C: MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Gross Salary or Wages	$_____	$_____
Social Security Benefits (include 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_____

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 $_____

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Recipient_____ Date_____ Amount $_____

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	HUSBAND	WIFE	JOINT	LIABILI-TIES
PERSONAL EFFECTS				
AUTOMOBILE				
BUSINESS INTEREST				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
SAVINGS CERTIFICATE				
RESIDENCE (ASSESSED VALUE) BLOCK#_____ LOT#_____ (Obtain from Tax Bill)				
ADDITIONAL AUTOMOBILES				
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 HOUSING EXPENSE

(Please divide annual expenses by 12 and quarterly expenses by 3)

$_____ Mortgage

$_____ Rent

$_____ Taxes

$_____ Water

$_____ Sewer

$_____ Utilities (Heat, Electric & Telephone)
(1/12th of Last 12 Months)

$_____ Homeowner's Insurance Premium

$_____ Condominium Fees

$_____ **Monthly Total**

PART H: 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 I: MONTHLY NON-SHELTER LIVING EXPENSES

$_____	Food
$_____	Medical
$_____	Clothing
$_____	Transportation (including auto insurance)
$_____	Home Maintenance
$_____	Life Insurance Premiums
$_____	Health Insurance Premiums
$_____	Cable TV
$_____	Other
$_____	**Monthly Total**

PART J: CHILDREN

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

PART K: GRANDCHILDREN

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

PART L: REFERRAL

By Whom Were You Referred to This Office?

Name _____

Address _____

PART M: 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:

Date: _____