Clingman Law Firm LLC
1522 Richland Street | PO Box 7096
Columbia, South Carolina 29202-7096
Office (803) 787-0557 Fax (803) 782-7607

Sarah Linley Clingman, CELA
Certified Elder Law Attorney
by The National Elder Law Foundation
Certified Circuit Court Mediator
Also admitted in Maryland

CONFIDENTIAL QUESTIONNAIRE
LONG TERM CARE PLANNING

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please answer each question completely. Place N/A in response to any question which does not apply to you.

Person Completing Questionnaire _____

If not Client, Relationship to Client _____

Address _____

_____

Telephone(s) _____

E-mail Address _____

By whom were you referred to this office _____

Specific issues or questions to be addressed_____
_____
_____

CERTIFICATION

We understand that Clingman Law Firm, LLC will rely on the information supplied by us in developing a long term care plan. We also understand that inaccurate or incomplete information could negatively impact our plan. Consequently, we agree to provide updated, accurate and complete information as requested within this Questionnaire and Checklist of Documents.

Signature of Client or Client Representative _____
Print Name _____
Date _____

Personal Information for Person Needing Long Term Care

Full Name _____

Age __ DOB __/__/____ SSN_____

U.S. Citizen? ☐ Yes ☐ No SC Resident? ☐ Yes ☐ No

Currently residing at:

☐ Personal Residence
Address _____ Home Phone _____
City/State/Zip Code _____ County_____

☐ Nursing Home or other assisted living facility
Name of Facility_____ Office Phone _____
Address _____ Admission Date_____
City/State/Zip Code _____ County_____

Cell Phone _____ E-mail Address _____

Veteran? ☐ Yes ☐ No If so, Branch of Service_____

Dates of service ___/___/_____ thru ___/___/_____ Rank at Discharge _____

Were you a prisoner of war during service? ☐ Yes ☐ No

Do you currently receive VA benefits? ☐ Yes ☐ No Type_____

Tell us about your parents:

	Mother	Father
Age of Death	_____	_____
Cause of Death	_____	_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list all former marriages

Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date of divorce_____
Was this marriage ended by death of spouse? Date & Place of death _____

Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date of divorce_____
Was this marriage ended by death of spouse? Date & Place of death _____

Personal Information for Spouse

Full Name _____

Age __ DOB __/__/____ SSN_____

U.S. Citizen? ☐ Yes ☐ No SC Resident? ☐ Yes ☐ No

Currently residing at:

☐ Personal Residence
Address _____ Home Phone _____
City/State/Zip Code _____ County_____

☐ Nursing Home or other assisted living facility
Name of Facility_____ Office Phone _____
Address _____ Admission Date_____
City/State/Zip Code _____ County_____

Cell Phone _____ E-mail Address _____

Veteran? ☐ Yes ☐ No If so, Branch of Service_____

Dates of service ___/___/_____ thru ___/___/_____ Rank at Discharge _____

Were you a prisoner of war during service? ☐ Yes ☐ No

Do you currently receive VA benefits? ☐ Yes ☐ No Type_____

Tell us about your parents:	Mother	Father
Age of Death	_____	_____
Cause of Death	_____	_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list all former marriages

Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date of divorce_____
Was this marriage ended by death of spouse? Date & Place of death _____

Spouse Name _____ Date of Marriage _____
Was this marriage ended by divorce? Date of divorce_____
Was this marriage ended by death of spouse? Date & Place of death _____

Children

List children, step-children, and legally adopted children for both spouses.

1. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

2. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

3. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

4. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

5. Relationship _____ Name _____ DOB __/__/____
   Address_____
   City_____ State _____ Zip Code _____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

Are all children in good health? ☐ Yes ☐ No
Are any children disabled? ☐ Yes ☐ No
Are any children receiving SSI or other government assistance? ☐ Yes ☐ No
Do all your children get along with one another? ☐ Yes ☐ No
Do any family members have problems with:
Drug addiction? ☐ Yes ☐ No Alcohol abuse? ☐ Yes ☐ No
Money management? ☐ Yes ☐ No
Their marriage or home life? ☐ Yes ☐ No
Do any children live with you? ☐ Yes ☐ No

Health Information

Have you been diagnosed with any illness or disability? If so, provide the following:

1. Husband Diagnoses_____
Wife Diagnoses_____

2. Husband Prognosis_____
Wife Prognosis_____

3. Husband Course of treatment_____
Wife Course of treatment_____

4. Husband Medications Prescribed

_____ _____ _____
_____ _____ _____
_____ _____ _____

Wife Medications Prescribed

_____ _____ _____
_____ _____ _____
_____ _____ _____

5. Activities of Daily Living

Feeds independently?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No
Dresses independently?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No
Bathes independently?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No
Transfers independently?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No
Toilets independently?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No
Requires supervision?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No

6. Capacity

Able to sign name?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No
Able to read & understand?	Husband	☐ Yes	☐ No	Wife	☐ Yes	☐ No

Been declared incompetent by court? Husband ☐ Yes ☐ No Wife ☐ Yes ☐ No

7. Husband Primary Physician

Name_____
Address_____
_____
Telephone_____
Specialty _____

Wife Primary Physician

_____
_____
_____
_____
_____

Health Insurance Information

Type	ID#	Carrier	Husband	Wife	Premium/Month
Medicare Part A					$
Medicare Part B					$
Medicare Part C					$
Medicare Pat D					$
Medicare Supplement					$
Medicaid					$
Private Health Plan					$
Long Term Care Plan					$
Retiree Health Plan					$
Other					$
Other					$

Monthly Income & Monthly Expenses

Please list joint sources of income and expenses.

MONTHLY INCOME

SOURCE	**Husband**	**Wife**
Social Security	$	$
Employment	$	$
Pension_____	$	$
IRA _____	$	$
Annuity_____	$	$
Rents	$	$
Business Interest	$	$
Gas Royalties	$	$
Other	$	$
Other	$	$
Other	$	$
TOTAL	**$**	**$**

MONTHLY EXPENSES

SOURCE	**Husband**	**Wife**
Medicare	$	$
Health Insurance	$	$
Taxes	$	$
Nursing Home or Other Facility	$	$
Caregivers	$	$
Prescriptions	$	$
Monthly Supplies	$	$
Other Costs	$	$
Other Costs	$	$
Other Costs	$	$
TOTAL	**$**	**$**

Summary of Assets

Nonretirement Accounts (Checking & Savings Accounts, CDs, Money Market Accounts, Brokerage Accounts, Stocks, Annuities or US Bonds)

Description	Account #	Value	In Whose Name?

Retirement Plans (IRAs, vested pension plans, annuities, or other assets that would pass on your death to a particular beneficiary that you have designated)

Description	Account #	Value	Beneficiary

Real Estate (Please list your personal residence first; also list mineral/oil rights)

Description/address	Purchase Date	Purchase Price	Current Value	In Whose Name?

Life Insurance

Insured	Company	Face Value	Cash Value	Policy No	Beneficiary

Other Business Interests

Description	Value	In Whose Name?

Personal Property (Autos, Boats, RVs, Appraised Antiques/Jewelry/Collections, etc)

Description	Value	In Whose Name?

Money Owed to You (promissory notes)

Type	Security	Repayment terms

Burial, Pre-Need Funeral Arrangements

Description	Company	Paid for?

TOTAL ASSET VALUES **$**_____

Have you made any transfers or gifts of $1000 or more during the past 5 years? ☐ Yes ☐ No
Recipient _____ Date of Gift _____ $_____
Recipient _____ Date of Gift _____ $_____
Recipient _____ Date of Gift _____ $_____

Do you expect an inheritance? ☐ Yes ☐ No

Are you the beneficiary of any trust? ☐ Yes ☐ No

Liabilities

Description	Balance	Monthly Payment	Secured?
Mortgage			
Other Mortgages			
Vehicle Loans			
Personal Loans			
Business Loans			
Credit Card Balances			
Other			
Other			
Other			

TOTAL LIABILITIES **$**_____

RECAP:

TOTAL ASSETS **$**_____
TOTAL LIABILITIES **- $**_____
NETWORTH **$**_____

Legal Assessment

Do you currently have the following estate planning documents in place?

	Date Made	Location of Original
• Last Will & Testament	_____	_____
• Health Care Power of Attorney	_____	_____
• Living Trust	_____	_____
• Durable Power of Attorney	_____	_____

Is DPOA Recorded in County ROD Office? ☐ Yes ☐ No

Location of other important papers _____
I am the legally appointed guardian of _____
I am serving as executor or administrator of an estate _____
I am involved in a lawsuit _____
Other legal concerns _____
_____
_____
_____
_____
_____

Persons Associated With Care Planning

1. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

2. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

3. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

4. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

5. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

6. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

7. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

8. Name _____ Relationship _____
   Address_____
   Home Phone_____ Work Phone _____
   Cell Phone _____ E-mail _____

Checklist of Documents

Please submit the following items prior to your consultation appointment along with your completed questionnaire and consultation fee.

- ☐ COPY of driver's license/ID card, social security card, and health insurance cards
- ☐ COPY of social security and/or retirement annual award letters
- ☐ COPY of military DD Form 214
- ☐ COPY of most current tax notices for all real estate owned
- ☐ COPY of deeds for all real estate owned
- ☐ COPY of titles to all vehicles, boats, RVs etc owned
- ☐ COPY of life insurance policies
- ☐ COPY of current statements for ALL financial assets (checking, savings, CD accounts, investment and brokerage accounts, and retirement accounts)
- ☐ COPY of current health care power of attorney, financial power of attorney, last will and testament/codicils, trust agreements
- ☐ COPY of pre-nuptial agreement, marriage license, separation/divorce decree – for all marriages
- ☐ COPY of adoption papers
- ☐ COPY of business ownership agreements
- ☐ COPY of pre-need/funeral arrangements contract
- ☐ COPY of the past 3 years tax returns and any gift tax returns