

Client Fact Find

Today's Date: _____

Name: _____ Spouse, if married: _____

Date of Birth: _____ Spouse's DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

1. **Marital Status:** Married Single Widowed Divorced
2. **Currently in need of care?** Yes No **If so, when?** _____
If so, who? _____

Type of care

- Skilled/Nursing Home Living Independently
 Living with family/friends Assisted Living

Relationship

- Mother Father
 Spouse Other

3. **If receiving care in a Nursing Home, date entered the care facility?** _____

Name of Facility: _____

Current Address if different from above (whether in a facility or not): Same as above

Monthly Cost of Care \$ _____

- Private Room
 Semi-Private Room
 Does the facility have Medicaid beds? Yes No Unknown

- 4a. **Is there a Long-Term Care Insurance Plan in place?** Yes No
If yes, who owns the policy? _____
If yes, is it a Partnership Plan? Yes No
If so, name of Insurance Company: _____
Daily/Monthly Benefit \$ _____ **Benefit Period:** _____

- 4b. **If you get sick and need LTC, where would you want to receive care?**
 At home Assisted Living Nursing Home
Assuming you need LTC, which asset would you liquidate first to pay for care?
 Checking/Savings IRA Annuities Stocks/Bonds/Mutual Funds

5. **Children's Names/Age (if any):**

Name	DOB

Pre-Screening Health Statement - Part A

	Client	Spouse (if applicable)
<p>1. Within the past two years have you been confined to a nursing home, assisted living center, received or been advised to receive hospice care, been advised that you have a terminal illness or need assistance with: bathing, eating, dressing, toileting, transferring into and out of bed, chair, or wheelchair and/or maintain continence?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. Are you currently hospitalized, bedridden or use medical devices such as: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair lift, chair lift, motorized scooter or taking medications Aricept, Exelon, Reminyl or Namenda?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Have you ever been diagnosed by a member of the medical profession as having AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. If under the age of 65, is there any reason you are not physically and mentally capable of active employment or are you currently receiving or have received within the past five years social security disability income benefits?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Have you ever been diagnosed, treated, tested positive for, or been given professional medical advice for: Alzheimer's disease, dementia, memory loss, multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig's disease) Parkinson's disease, down syndrome, organ transplant (other than kidney) or active cancer?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Client Pre-Screening Health Statement - Part B

Client: _____

1. Check all activities of daily living that require assistance or supervision:

- Bathing Transferring Dressing Toileting Eating Continence

Comments: _____

2. Height: _____ **Weight:** _____

3. Medications:

Medication	Dose	Frequency	Reason

4. Is there a history of:

- Diabetes (If YES, please fill out the Diabetes questionnaire)
 Depression (If YES, please fill out the Depression questionnaire)
 Coronary Artery Disease (If YES, please fill out the Coronary Artery Disease questionnaire)
 Cancer (If YES, please fill out the Cancer questionnaire)
 Chronic Obstructive Pulmonary Disease (COPD) (If YES, please fill out the COPD questionnaire)

Other: _____

5. Comments:

Spouse Pre-Screening Health Statement - Part B

Spouse: _____

1. Check all activities of daily living that require assistance or supervision:

Bathing Transferring Dressing Toileting Eating Continence

Comments: _____

2. Height: _____ **Weight:** _____

3. Medications:

Medication	Dose	Frequency	Reason

4. Is there a history of:

- Diabetes (If YES, please fill out the Diabetes questionnaire)
- Depression (If YES, please fill out the Depression questionnaire)
- Coronary Artery Disease (If YES, please fill out the Coronary Artery Disease questionnaire)
- Cancer (If YES, please fill out the Cancer questionnaire)
- Chronic Obstructive Pulmonary Disease (COPD) (If YES, please fill out the COPD questionnaire)

Other: _____

5. Comments: _____

Financial Information

1. Own Home? Yes No Value \$ _____
2. Outstanding Mortgage \$ _____ Cost Basis \$ _____
3. Principal and interest payments \$ _____ Taxes/Insurance payment \$ _____
4. Own other property/real estate? Yes No Description: _____
 Value \$ _____ Mortgage \$ _____ Cost Basis \$ _____

5. Monthly Income:

Type	Client Income	Spouse Income
Social Security		
Gross Wages		
Pensions		
Spousal Pension Continuation Benefit		
Military Retirement		
Interest/Dividends		
Investment Property		
Income from IRA's		
Other		
Other		
TOTAL		

6. Do you rely on IRA Income for living expenses? Yes No

7. Monthly Expenses:

Type	Client Income	Spouse Income
Medicare Part B		
Medicare Part C &/or D		
Private Med. Insurance		
Prescriptions		
Home Care/AL/NH		
Incontinence Supplies		
Other		
Other		
Other		
Other		
TOTAL		

8. Assets:

Checking/Savings Acct.	Owner of Acct.	Value of Acct.
TOTAL		

C.D.'s/Money Markets	Owner of Acct.	Value of Acct.
TOTAL		

Stocks/Bonds	Owner	Value of Acct.	Cost Basis
TOTAL			

Annuities	Owner	Value	Cost Basis	Surrender Value
TOTAL				

Mutual Funds	Owner	Value of Acct.	Cost Basis
TOTAL			

Qualified Accounts	Owner	Investment Type	Value of Acct.	Surrender Value
TOTAL				

Legal Information

1. Is there a Durable Power of Attorney in place? Yes No

If so, who is listed as the POA? _____

2. Is there a Will in place? Yes No

3. Is there a Trust? Yes No Name of Trust: _____

Is the Trust Revocable Irrevocable Tax ID# of Trust: _____

4. Is there a prepaid burial/funeral plan in place? Yes No If so, \$ _____

Comments/Notes: _____

IMPORTANT: This Section Must Be Completed

Agent Contact Information

Firm: _____

Address: _____

Email: _____

Phone: _____ Fax: _____

Diabetes Questionnaire

Your Name: _____

1. Approximate date first diagnosed: _____

2. How often do you visit your physician? _____

3. My diabetes is controlled by:

Diet alone

Oral medication (medication and doses) _____

Insulin (amount and units/day) _____

4. Please give the most recent glucose blood sugar reading: _____

5. Do you monitor your own blood sugar? Yes No

6. Please give your most recent A1c reading: _____

7. Please check if you have (had) any of the following:

Chest pain or coronary artery disease

Protein in the urine

Elevated lipids

Overweight

Neuropathy

Kidney disease

Retinopathy

Abnormal ECG

Hypertension

Depression Questionnaire

Your Name: _____

1. List the diagnosis: _____

2. Please indicate:

Number of episodes: _____ Date of last episode: _____

3. Are you on any medications? Yes No

If yes, give accurate name, dosage, and reason: _____

4. Have you been diagnosed for psychiatric treatment? Yes No

If yes, give dates and lengths of stay: _____

5. Do you have a history of any of the following associated conditions? (Check all that apply):

- Personality disorder Psychotic disorder
 Suicidal thoughts/attempts Substance abuse (alcohol or drugs) [Complete questionnaire]
 Other psychiatric disorder

6. Are you currently working? (Occupation): _____

7. Has any time been lost from work as a result of condition? Yes No

If yes, give details: _____

Coronary Artery Questionnaire

Your Name: _____

1. List approximate date(s) of diagnosis and type of coronary artery disease:

2. Do you have a family history of heart disease? Yes No

If yes, list family member and details: _____

3. Have you had any of the following?:

Heart attack Date: _____

Coronary angioplasty (PTCA) Date: _____

Heart failure Date: _____

Valve Surgery Date: _____

Bypass Surgery Date: _____

4. Please check if you have (had) any of the following:

Abnormal lipid levels Diabetes Overweight Elevated homocysteine

High blood pressure Peripheral vascular disease Irregular heart beats

Cerebrovascular or carotid disease Elevated cholesterol

5. Are you on any medications? Yes No

If yes, give accurate name, dosage, and reason: _____

Cancer Questionnaire

Your Name: _____

1. What type of cancer was diagnosed? _____

2. List approximate date of first diagnosis: _____

3. Is there a family history of cancer? Yes No

If yes, give details: _____

4. How was the cancer treated?

Surgery

Chemotherapy

Radiation therapy

Hormonal therapy

Immunotherapy

Other (give full details) _____

5. List date treatment was completed: _____

6. What was the stage and grade of the cancer? _____

7. Has there been any evidence of reoccurrence? Yes No

If yes, give details: _____

8. What did the pathology report reveal? _____

9. Are you on any medications? Yes No

If yes, give accurate name, dosage, and reason: _____

Chronic Obstructive Pulmonary Disease (COPD) Questionnaire

Your Name: _____

1. What is the type of lung disease?

- Chronic bronchitis Emphysema Restrictive lung disease Asthma

2. Please list approximate date when first diagnosed: _____

3. Have you ever been hospitalized for this condition? Yes No

If yes, give details: _____

4. Have you ever smoked?

Yes, and currently smoke _____ (amount/day)

Yes, smoked in the past but quit _____ (date)

Never smoked

5. Are you on any medications? Yes No

If yes, give accurate name, dosage, and reason; include inhalers: _____

6. Have pulmonary function tests (a breathing test) ever been done? Yes No

If yes, give most recent test results: _____

7. What is your Height? _____ Weight? _____

8. Do you have any abnormalities on an ECG or X-ray? Yes No

If yes, give details: _____
