GRADY H. WILLIAMS, JR., LL.M.
ATTORNEYS AT LAW, P.A.

Alison E. Hickman
Alison@FloridaElder.com

Grady H. Williams, Jr., LL.M.
Master of Laws in Taxation
Grady@FloridaElder.com

MAIN OFFICE AND MAILING ADDRESS
1543 Kingsley Avenue
Building 5
Orange Park, FL 32073

JACKSONVILLE OFFICE*
7807 Baymeadows Road East
Suite 402-A
Jacksonville, FL 32256
*By Appointment

ST. AUGUSTINE OFFICE*
179 King Street
St. Augustine, FL 32084
*By Appointment

Tel: 904-264-8800 www.FloridaElder.com Fax: 904-264-0155

Confidential Long Term Care Planning Information

Thank you for contacting us for a legal consultation regarding long-term care planning and options. In order to provide you with proper advice, we must fully understand the issues you face. Please call us at **(904) 264-8800** if you have any questions or concerns about completing this form.

These questions pertain to the person or persons for whom we are planning.

Please complete the following questionnaire to the best of your ability, and bring it with you to the consultation. Feel free to add any information you feel would be helpful, write on the back of the form, or make notes. **Please bring other documents you may have to the consultation, such as trusts, wills, power of attorney documents, deeds, and asset statements (such as bank accounts, brokerage accounts, etc.).**

Date:_____ Referred by:_____

I. Personal Information

Name:		Spouse:	
Address:		Address:	
Home Phone:		Home Phone:	
Cell Phone:		Cell Phone	
Email address:		Email address	
Date of birth:		Date of birth:	
Place of Birth:		Place of Birth:	
Social Security Number:		Social Security Number:	
U. S. citizen?	☐ Yes ☐ No	U. S. citizen?	☐ Yes ☐ No

Marriage Information:

Date and place of marriage: _____

Previous marriage information: _____

Military Service:

Veteran?	☐ Yes ☐ No	Veteran?	☐ Yes ☐ No
Retired Veteran?	☐ Yes ☐ No	Retired Veteran?	☐ Yes ☐ No
Disabled Veteran?	☐ Yes ☐ No	Disabled Veteran?	☐ Yes ☐ No
Branch of Service	☐ USA ☐ NAVY ☐ USMC ☐ USCG	Branch of Service	☐ USA ☐ NAVY ☐ USMC ☐ USCG
Enrolled with VA?	☐ Yes ☐ No	Enrolled with VA?	☐ Yes ☐ No
Dates of Service?		Dates of Service?	

Children (names, addresses, telephone numbers, dates of birth):

1. _____

2. _____

3. _____

4. _____

5. _____

Primary Point of Contact: If not you, who is your "Contact Person" (the person we should contact for appointments, for more information about you, etc.)?:_____

Currently living at home? If not, list:
Name, Address and Telephone number of facility: _____
_____

Date of admission to the living facility: _____

Please provide a brief health history, include any recent hospitalizations, diagnosis, and include any issues regarding dementia and mental capacity – please use separate sheet as needed: _____
_____
_____
_____

Please provide a list of your current medications (may provide on separate sheet of paper): _____
_____

What is the total monthly medication expenses? _____

Please provide a summary of your current or long-term concerns/issues:
_____
_____
_____
_____

Activities of Daily Living: Please identify current level of independence of client?	**Please check most appropriate answer.**
What is level of mobility?	☐Independent ☐ cane ☐walker ☐wheelchair ☐ bed bound
Manages household tasks, housekeeping, cooking, and errands independently?	☐ Yes ☐ No ☐ With assistance
Manages finances independently?	☐ Yes ☐ No ☐ With assistance
Are there behavior issues such as aggression, sundowners or hitting or combative behaviors?	☐ Yes ☐ No
Wanders or seeks exits or states frequently, I want to go home?	☐ Yes ☐ No
Assistance with eating?	☐ Yes ☐ No
Assistance with toileting or experience incontinence?	☐ Yes ☐ No
Assistance with bathing and/or daily hygiene, changing clothes?	☐ Yes ☐ No ☐ Not applicable
Require Diabetic Care?	☐ Yes ☐ No ☐ Not applicable
Been told requires supervision 24/7?	☐ Yes ☐ No ☐ Not applicable
Any ongoing medical treatments such as dialysis, chemotherapy, ostomy care, wound care, feeding tubes, etc? If yes, please explain on separate sheet of paper. Diagnosed with degenerative eye diseases or untreated eye diseases causing permanent diminishment of vision or blindness?	☐ Yes ☐ No ☐ Not applicable ☐ Yes ☐ No ☐ Not applicable
Been told may not continue to drive or have driving restrictions?	☐ Yes ☐ No ☐ Not applicable

Please list if you have any of the following insurances:
Primary Health Insurance: _____
Supplement Health Insurance: _____
Long Term Health Insurance:_____
Cancer Policy:_____
Workman's Compensation: _____

Please list your primary care physician:

_____

_____

Do you have any of the following documents?	**Husband**	**Wife**
Durable Power of Attorney	☐ Yes ☐ No	☐ Yes ☐ No
Health Care Power of Attorney	☐ Yes ☐ No	☐ Yes ☐ No
Living Will	☐ Yes ☐ No	☐ Yes ☐ No
Will	☐ Yes ☐ No	☐ Yes ☐ No
Revocable Living Trust	☐ Yes ☐ No	☐ Yes ☐ No

Please bring copies of all estate planning documents, power of attorney documents, supporting policies, etc. to our office prior to the meeting.

II. Resources

Gross Monthly Income

Do not list interest or dividend income.

	Husband	Wife
Source		
Social Security:		
Pension:		
Military Disability or other disability:		
Other:		
Total:		

Real Estate You Own

A. Personal Residence

Address of property:_____

B. Other Real Estate

Address of property:_____

C. Business

Address and type of business:_____

Other Assets: Your bank accounts, CDs, annuities, stocks, retirement plans, and the like.

Type of Asset	Company Name	How Is It Titled?	Value

Life Insurance	Policy 1	Policy 2
Company Name		
Owner of Policy		
Insured		
Beneficiary		
Death Benefit (face value)		
Current Cash Value (if any)		
Loan Against Policy (if any)		

List large items of personal property you own (cars, boats, RVs, motorcycles, etc.):

Personal Property (Item)	Value

Do you have a prepaid funeral or burial? ☐ Yes ☐ No If yes, what is the cost of the prepaid expenses? $ _____
If yes, describe the arrangements:

_____

_

Use this space and additional sheets for additional information as needed.

Name(s) of person(s) filling out this form: _____

Thank you for taking the time to complete this form.

Life Care Planning Law Firms Association MEMBER

NAELA National Academy of Elder Law Attorneys, Inc. MEMBER

AFELA advocate educate action The Academy of FLORIDA ELDER LAW ATTORNEYS