PERSON COMPLETING THIS FORM

Name of Person Completing This Form:

Relation to Client / Applicant

Referred By

Email Address

Phone Number and Type (cell/home)

If Agent under Power of Attorney — Date of POA:

If Agent under POA — Full Address (Street, City, State, ZIP):

Have you managed the Applicant's finances for the past five years?

○ Yes ○ No

Do you have bank statements & records for that period? (Y/N)

Does the Applicant have them? (Y/N)

If No — Who was handling assets prior to your involvement?

Are records available for that period? (Y/N)

CLIENT INFORMATION

Full Legal Name of Client:

Client's Home Address (Street, City, State, ZIP):

Client's Date of Birth:

County of Domicile

Municipality (property taxes)

School District

Marital Status:

○ Divorced ○ Single ○ Widow or Widower ○ Separated

Name of ex-spouse / deceased spouse

Date of divorce / death / separation

Divorce petition filed? (Y/N / How long separated)

Does the Client own the residence?

○ Yes ○ No

Any mortgages against the property? Amount owed?

If renting — how much is the rent?

Is anyone residing with the Client?

○ Yes ○ No

Who and for how long?

Relationship to Client

Personal physician aware? (Y/N — if 2+ years)

Is the Client currently in a Nursing Facility?

○ Yes ○ No

Name of Facility

Admission Date (MM/DD/YYYY)

Date Paid Through

Covered by Medicare? (Y/N)

When does Medicare coverage end?

If NOT in facility — where residing?

Is a family member residing with the Client?

○ Yes ○ No

Name of Family Member

How long living with Client?

MILITARY SERVICE

If medical expenses exceed income, the Client may qualify for Veterans Benefits including Aid and Attendance.

Is the Client a veteran?

○ Yes ○ No

Dates of Service

Do you have your DD-214? (Y/N)

Applied for or receiving Veterans Benefits? (Y/N — incl. Aid & Attendance)

HEALTH INSURANCE

Client's Health Insurance:

○ Private Policy ○ Medicare HMO (Medicare Advantage) ○ Medicare + Supplement

○ Tricare ○ Part D Only ○ Unknown

Insurance Company / Provider Name | **Monthly Cost ($)** | **Part D Provider and Cost**

Supplemental Insurance Provider | **Supplement Monthly Cost ($)** | **Tricare — Registered for DEERS? (Y/N)**

Does the Client have a family doctor?

○ Yes ○ No

Name of Doctor | **Practice Name, Address and Fax Number**

Client's Diagnosis:

Client's Prognosis — Has a doctor recommended treatment? Has an MA-41 been completed?

Does the Client have Long Term Care Insurance?

○ Yes ○ No

Name of Company | **Daily Benefit Rate ($)** | **Has the policy been used? (Y/N)**

PRIMARY CONTACT / AGENT

Primary contact is usually the agent under the Power of Attorney.

Full Name (as named on POA document) | **Relation to Client**

Street Address (if not already provided above):

City | **State** | **ZIP** | **Date of Birth (MM/DD/YYYY)**

Cell Phone | **Email** | **Alternative Email**

If Agent — Date of POA:

SECOND CONTACT PERSON

Full Legal Name

Relation to Client

Street Address:

City

State

ZIP

Date of Birth (MM/DD/YYYY)

Cell Phone

Email

Alternative Email

ESTATE PLANNING DOCUMENTS & ASSETS

Check all documents the Client currently has. Please attach the Power of Attorney.

Which of the following does the Client currently have?

- ☐ Last Will & Testament
- ☐ Power of Attorney
- ☐ Living Will / Health Care Directive
- ☐ Living Trust
- ☐ Irrevocable Trust

A safe deposit box may require probate to access after death. We advise closing it as part of asset protection planning.

Does the Client have a safe deposit box?

○ Yes ○ No

Where is it located?

Is the key available?

How is it titled?

What is in the box?

Has the Client made any gifts in the last 5 years?

○ Yes ○ No

Does the Client or Contact have financial records (bank statements, etc.)?

○ Yes ○ No

If Yes — Where are the records and who has possession of them?

Appointment Date | **Attorney** | **Paralegal**

Thank You!

Thank you for completing this intake questionnaire. This information will be extremely helpful in evaluating your case. We will contact you as soon as possible with any updates.

Shober & Rock, P.C. · 308 N. Main St., Suite 400, Chalfont, PA 18914 · shober-rock.com

Please attach the Power of Attorney and bring any relevant financial records to your appointment.