PERSON COMPLETING THIS FORM

Who is completing this form?

○ Husband / Partner A ○ Wife / Partner B ○ Family Member ○ Facility Employee

Full Name | **Relationship to Clients** | **Named in Power of Attorney? (Y/N)**

Best Cell Phone Number | **Email Address** | **Referred By**

Agent's Full Address (Street, City, State, ZIP):

CLIENT A — PRIMARY CLIENT / ILL SPOUSE

Client A is typically the ill spouse or the primary client requiring care planning.
Please provide full legal names including middle initials.

Full Name with Middle Initial(s):

Name on Driver's License, SS Card or Passport | **Other Names Used**

Date of Birth:

Home Phone | **Cell Phone** | **Email Address**

Client A — Preferred Contact Method:

○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email Only ○ Regular Mail

CLIENT B — COMMUNITY SPOUSE / WELL SPOUSE

Client B is the spouse who is not ill, also known as the 'community spouse.'

Full Name with Middle Initial(s):

Name on Driver's License, SS Card or Passport

Other Names Used

Date of Birth:

Home Phone

Cell Phone

Email Address

RESIDENCE

Home Address (Street, City, State, ZIP):

County

Municipality (for property taxes)

School District

Name(s) on your Deed (please bring a copy of your Deed to your appointment):

MARITAL INFORMATION

Date of Marriage:

Place of Marriage (City, State):

Do you have children from your current marriage?

◯ Yes ◯ No

Number of children:

Na Domicile, Cell Phone and Email Addresses:

Client A — Previous Marriage?

◯ Yes ◯ No

If Yes — When and how was the marriage ended? Name of prior spouse?

Client A — Children from prior marriage(s)?

Yes No

Number of children:

Na… Domicile, Cell Phone and Email Addresses:

Client B — Previous Marriage?

Yes No

If Yes — When and how was the marriage ended? Name of prior spouse?

Client B — Children from prior marriage(s)?

Yes No

Number of children:

Na… Domicile, Cell Phone and Email Addresses:

HEALTH INFORMATION

Name of Ill Spouse

Diagnosis

Prognosis — What type of treatment is recommended for the ill spouse?

Ill Spouse's Physician — Practice name, address, fax number, how long treating:

Course of Treatment:

Where Ill Spouse Currently Resides

Where Well Spouse Currently Resides

Health of Well Spouse:

If either spouse has entered a nursing home — name of the facility:

Date of Admission:

Facility Payment Method

How is the facility currently being paid?

○ Medicare (rehab bed) ○ Private Pay ○ LTC Insurance

Has Medicare advised of end of coverage? (Y/N)

Private Pay start date

LTC: start date & daily benefit ($)

ESTATE PLANNING DOCUMENTS

Please check all documents you currently have and bring copies to your appointment.
The Power of Attorney for the ill spouse is especially important — please attach if available.

Which of the following do you currently have?

☐ Last Will & Testament
☐ Living Will
☐ Power of Attorney
☐ Trust

Is there a safe deposit box?

○ Yes ○ No

Where is it located?

What are the contents?

How is it titled?

Is the key available to your agents? (Yes / No / Location):

MILITARY SERVICE

If your medical expenses are greater than your income, you may be entitled to certain benefits as a former service member. Please answer the questions below carefully.

Did either spouse serve in the military?

○ Yes ○ No

Which spouse served?

Dates of service

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

Appointment Date

Attorney

Paralegal

Thank You!

Thank you for completing this 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 bring copies of any Powers of Attorney and your Deed to your appointment.