



Law Offices of Gary Cornick, LLC

LAW OFFICE OF GARY CORNICK, LLC
210 EAST MAIN STREET
SOMERVILLE, NJ 08876
(908) 253-0404

ELDER LAW PLANNING QUESTIONNAIRE (Married)

Date _____ Tel. Home _____ Tel. Bus. _____

PART A: PERSONAL INFORMATION

CLIENT HUSBAND

Full Name _____ Address _____

a/k/a _____ Zip _____

U.S. Citizen? Yes _____ No _____ Birth Date _____

Social Security Number _____

Name of Primary Physician _____

Address of Primary Physician _____

CLIENT WIFE

Full Name _____ Address _____

a/k/a _____ Zip _____

U.S. Citizen? Yes _____ No _____ Birth Date _____

Social Security Number _____

Name of Primary Physician _____

Address of Primary Physician _____

Are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program)?

Yes _____ No _____

CHILDREN

Are any of your children blind? Yes __ No

Are any of your children disabled? Yes __ No

Do any of your children live with
you in your home? Yes __ No

PART B: MISCELLANEOUS INFORMATION

Age of Husband _____

Age of Wife _____

If either spouse is in a nursing home or contemplates entering a nursing home, please list the following:

Name of Ill Spouse _____

Diagnosis _____

Prognosis _____

Course of Treatment _____

Name of Well Spouse _____

Health of Well Spouse _____

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis:

PART C: MONTHLY INCOME

| | Husband's Monthly Income | Wife's Monthly Income |
|---|-----------------------------|--------------------------|
| Gross Salary or Wages | \$ _____ | \$ _____ |
| Social Security Benefits (include Medicare Part B Deduction, if applicable) | _____ | _____ |
| Retirement Benefits | _____ | _____ |
| Interest | _____ | _____ |
| Dividends | _____ | _____ |
| Other | _____ | _____ |
| TOTAL INCOME | \$ _____ | \$ _____ |

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance or any other reason.

Gross Amount: \$ _____ (include all deductions)

Could this pension amount increase in the future? Yes _____ No _____

PART D: GIFTS

(Gifts made in excess of \$1,000/year to an individual other than your spouse within the past 60 months)

| | | |
|-----------------|------------|-----------------|
| Recipient _____ | Date _____ | Amount \$ _____ |
| Recipient _____ | Date _____ | Amount \$ _____ |
| Recipient _____ | Date _____ | Amount \$ _____ |
| Recipient _____ | Date _____ | Amount \$ _____ |
| Recipient _____ | Date _____ | Amount \$ _____ |
| Recipient _____ | Date _____ | Amount \$ _____ |
| Recipient _____ | Date _____ | Amount \$ _____ |
| Recipient _____ | Date _____ | Amount \$ _____ |

PART E: ASSETS

Please insert the approximate value of each asset/liability in the appropriate space.

| ASSETS | HUSBAND | WIFE | JOINT | LIABILITIES |
|---|---------|------|-------|-------------|
| PERSONAL EFFECTS | | | | |
| AUTOMOBILE | | | | |
| BUSINESS INTEREST | | | | |
| CHECKING ACCOUNT | | | | |
| SAVINGS ACCOUNT | | | | |
| MONEY MARKET ACCOUNT | | | | |
| SAVINGS CERTIFICATE | | | | |
| RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ (Obtain from Tax Bill) | | | | |
| ADDITIONAL AUTOMOBILES | | | | |
| OTHER REAL ESTATE | | | | |
| MUTUAL FUNDS | | | | |
| STOCKS | | | | |
| BONDS | | | | |
| ANNUITIES | | | | |
| CASH VALUE - LIFE INS | | | | |
| IRA | | | | |
| NURSING HOME DEPOSIT | | | | |
| OTHER | | | | |
| | | | | |
| TOTALS | | | | |

If any of your accounts are joint with children, please so indicate. If the account is "or", indicating with **one asterisk**. If the account is "and", indicate with **two asterisks**.

Address of any real property other than personal residence:

Street _____ City _____ State _____ Zip _____
Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

Street _____ City _____ State _____ Zip _____
Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for your current home including any improvements?

\$ _____

Name of Homeowner's Insurance Company:

Address:

Phone #: _____

PART F: LIFE INSURANCE

| COMPANY (include Address and Policy Number) | TYPE | DEATH BENEFIT VALUE | FACE VALUE | CASH VALUE | INSURED | OWNER | BENEFI- CIARY |
|---|------|---------------------------|---------------|---------------|---------|-------|------------------|
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It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

(Include the cash value of the Life Insurance on the Life Insurance line in Part E above)

PART G: MONTHLY HOUSING EXPENSE

(Please divide annual expenses by 12 and quarterly expenses by 3)

- \$_____ Mortgage
- \$_____ Rent
- \$_____ Taxes
- \$_____ Water
- \$_____ Sewer
- \$_____ Utilities (Heat, Electric & Telephone)
(1/12th of Last 12 Months)
- \$_____ Homeowner's Insurance Premium
- \$_____ Condominium Fees

- \$_____ **Monthly Total**

PART H: MONTHLY COST OF NURSING HOME

- \$_____ Cost Per Month
- \$_____ Prescription Cost per Month
- \$_____ Incontinent Cost per Month
- \$_____ Other per Month

- \$_____ **Monthly Total**

The nursing home is paid through the month of _____.

PART I: MONTHLY NON-SHELTER LIVING EXPENSES

| | |
|----------|---|
| \$ _____ | Food |
| \$ _____ | Medical |
| \$ _____ | Clothing |
| \$ _____ | Transportation (including auto insurance) |
| \$ _____ | Home Maintenance |
| \$ _____ | Life Insurance Premiums |
| \$ _____ | Health Insurance Premiums |
| \$ _____ | Cable TV |
| \$ _____ | Other |
| \$ _____ | Monthly Total |

PART J: CHILDREN

| CHILDREN'S NAMES | ADDRESS WITH ZIP CODE | TELEPHONE NUMBER | DATE OF BIRTH |
|------------------|-----------------------|------------------|---------------|
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PART K: GRANDCHILDREN

| GRANDCHILDREN'S NAMES | ADDRESS WITH ZIP CODE | TELEPHONE NUMBER | DATE OF BIRTH |
|-----------------------|-----------------------|------------------|---------------|
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PART L: REFERRAL

By Whom Were You Referred To This Office?

Name _____

Address _____

PART M: SIGNATURE

The undersigned hereby represents to the Law Offices of Gary Cornick, LLC, and each of its attorneys, that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information which I am furnishing, but will **not** independently verify its accuracy. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

Date: _____