LONG TERM CARE
PLANNING INFORMATION SHEET

IT IS VERY IMPORTANT THAT THIS DOCUMENT BE COMPLETED AND RETURNED TO KEIBER SENIOR SERVICES AT LEAST ONE DAY PRIOR TO OUR APPOINTMENT. IF YOU ARE NOT ABLE TO OBTAIN ALL OF THE VERIFICATIONS, PLEASE BRING WHAT YOU ARE ABLE TO FIND TO THE APPOINTMENT.

PLEASE REFER TO THE CHECKLIST ON PAGES 14, 15 and 16.

SECTION 1 – HUSBAND

I. General Information

1. **Husband's LEGAL Name:** _____

Form of government issued photo identification:
Driver License ☐ **Passport** ☐ **FL ID** ☐ **Other** ☐_____

If this individual does not have a valid Driver License or Passport,
a Florida Identification card can be obtained at
by locating one of the DMV offices listed:
www.DMVFlorida.org

2. **Current or last home address:** _____
_____

Telephone Number: _____

Is this address the individual's "Homestead"? Yes ☐ **No** ☐

3. **E-mail Address:** _____

4. **Date of birth:** _____ **SS#:** _____

5. **If Husband is in Long Term Care; what is the Name and Address of the Facility?** _____

Contact Name: _____ **Telephone Number:** _____

Date of Admission: _____

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II. Insurance Information

1. **Medicare #: _____ Start Date: _____**

2. **Secondary Insurance Company: _____**

   Policy Number: _____ Address: _____

   _____

   Telephone Number: _____Premium: $ _____

   How is the premium paid? _____

3. **Prescription coverage carrier: _____**

   Policy Number: _____ Address: _____

   _____

   Telephone Number: _____Premium: $ _____

   How is the premium paid? _____

4. **If we are applying for Medicaid, does this company work with Dual Eligible Individuals? Yes ☐ No ☐**

III. Military Information

1. **Dates of Military Service: _____**

2. **Branch of Service: _____ Honorably discharged? Yes ☐ No ☐**

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IV. Marital / Family Information

1. Please complete if there have been prior marriages.

	Date(s) of prior marriage(s)	How did marriage end?
1.	_____	_____
2.	_____	_____
3.	_____	_____

2. Children from current marriage:

	Name	Address	Phone	DOB
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

3. Children from prior marriage(s):

1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

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V. Medical Information:

1. **Husband's Primary Care Physician:** _____

   Address: _____

   Telephone Number: _____

VI. Legal Information

1. **Name of Husband's Power of Attorney:** _____

   Address: _____

   Home telephone #: _____ **Cellular telephone #:** _____

   E-mail address: _____

   Name of second Power of Attorney (if any): _____

   Address: _____

   Home telephone #: _____ **Cellular telephone #:** _____

   E-mail address: _____

2. **Name of Health Care Surrogate:** _____

   Address: _____

   Home telephone #: _____ **Cellular telephone #:** _____

   E-mail address: _____

3. **Does husband have pre-paid Funeral Arrangements: Yes ☐ No ☐**

   With whom :_____

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SECTION 2 – WIFE

I. General Information

1. Wife's LEGAL Name: _____

Form of government issued photo identification:
Driver License ☐ Passport ☐ FL ID ☐ Other ☐_____

If this individual does not have a valid Driver License or Passport,
a Florida Identification card can be obtained at
by locating one of the DMV offices listed:
www.DMVFlorida.org

2. Current or last home address: _____

_____

Is this address the individual's "Homestead"? Yes ☐ No ☐

3. E-mail Address: _____

4. Date of birth: _____ **SS#:** _____

5. If Wife is in Long Term Care; what is the Name and Address of the Facility?

_____

Contact Name: _____ **Telephone Number:** _____

Date of Admission: _____

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II. Insurance Information

1. **Medicare #: _____ Start Date: _____**

2. **Secondary Insurance Company: _____**

   Policy Number: _____ Address: _____

   _____

   Telephone Number: _____Premium: $ _____
   How is the premium paid? _____

3. **Prescription coverage carrier: _____**

   Policy Number: _____ Address: _____

   _____

   Telephone Number: _____Premium: $ _____

   How is the premium paid? _____

4. **If we are applying for Medicaid, does this company work with Dual Eligible Individuals? Yes ☐ No ☐**

III. Military Information

1. **Dates of Military Service: _____**

2. **Branch of Service: _____ Honorably discharged? Yes ☐ No ☐**

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IV. Marital / Family Information

1. Please complete if there have been prior marriages.

	Date(s) of prior marriage(s)	How did marriage end?
1.	_____	_____
2.	_____	_____
3.	_____	_____

2. Children from current marriage:

	Name	Address	Phone	DOB
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

3. Children from prior marriage(s):

1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

V. Medical Information:

1. **Wife's Primary Care Physician:** _____

Address: _____

Telephone Number: _____

VI. Legal Information

1. **Name of Wife's Power of Attorney:** _____

Address: _____

Home telephone #: _____ **Cellular telephone #:** _____

E-mail address: _____

Name of second Power of Attorney (if any): _____

Address: _____

Home telephone #: _____ **Cellular telephone #:** _____

E-mail address: _____

2. **Name of Health Care Surrogate:** _____

Address: _____

Home telephone #: _____ **Cellular telephone #:** _____

E-mail address: _____

3. **Does wife have pre-paid Funeral Arrangements: Yes ☐ No ☐**

With whom :_____

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SECTION 3 –
INCOME/ASSETS/OBLIGATIONS/EXPENSES/TRANSFERS

I. Individual gross income:

* We will need verification of income "from the source." Although income may be directly deposited into a bank account, we must have verification from the company or organization that generates the income. Bank Statements are not sufficient. ***NOTE: IF WE WILL BE APPLYING FOR MEDICAID FOR THIS INDIVIDUAL AND THEIR TOTAL GROSS MONTHLY INCOME MEETS OR EXCEEDS THE MAXIMUM ALLOWABLE INCOME FOR MEDICAID, A QUALIFIED INCOME TRUST MAY BE NEEDED.***

1. Please list all income for Husband:

Source	Gross Amt*	Deductions	Frequency

2. Please list all income for Wife:

Source	Gross Amt*	Deductions	Frequency

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II. ASSETS*:*

1. Please list ALL assets:

Asset Type	Name of Institution	Titled Owner(s)	Account Number	Account Balance
Checking				$
Savings				$
Life Insurance				$
Annuity				$
CD				$
IRA				$
				$
				$
				$

2. Please list ALL properties (real and land):

Type	Owner(s)	Address	Balance	Value
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

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3. Please list ALL vehicles (automobiles, boats, RV, etc.):

Type	Owner(s)	YR/Make/Model	Balance	Value
_____	_____	_____	$_____	$_____
_____	_____	_____	$_____	$_____
_____	_____	_____	$_____	$_____
_____	_____	_____	$_____	$_____

III. Obligations:

Please provide us with the most recent statement, bill, coupon book or legal agreement.

1. Please list ALL debts owed:

Company	Account Number	Balance	Payment
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____

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2. Please list ALL household expenses:

Expense	Account Number	Balance	Payment
Mortgage/Rent	_____	$_____	$_____
HOA Fee	_____	$_____	$_____
Property Taxes	_____	$_____	$_____
Property Insurance	_____	$_____	$_____
Nursing Home	_____	$_____	$_____
Electric	_____	$_____	$_____
Utilities	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____
_____	_____	$_____	$_____

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IV. TRANSFERS/GIFTS Information

1. **Please list any transfers of assets or gifts made within five years of today's date*:**

Date of Transfer	Made by	To whom	Amount
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

***Gifts and transfers of assets may subject the potential Medicaid applicant to a period of ineligibility for Medicaid benefits.**

ESSENTIAL DOCUMENT CHECKLIST

SECTION 1 and SECTION 2

I. General Information

☐ **Valid Photo ID** ☐ **Social Security card**

II. Insurance Information

☐ **Medicare card** (both sides) ☐ **Medical Insurance card** (both sides)
☐ **Birth certificate** ☐ **Prescription card****
☐ **Verification of Health Insurance or Medicare Supplement Premium. (This must be from the company that the coverage is through)**
☐ **Verification of any Long Term Care Insurance.**

III. Military Information

☐ **DD214 or Separation Papers**
☐ **A list of ALL medical and health insurance expenses incurred**

IV. Marital / Family Information

☐ **Marriage License**

V. Medical Information

☐ **Proof of ongoing medical expenses** (ex. Home care, assisted living, durable medical equipment, oxygen, etc…)

VI. Legal Information

☐ **Living Will** ☐ **Power of Attorney** ☐ **Trusts** (any Amendments)
☐ **Designation of Health Care Surrogate**
☐ **Last Will & Testament/Codicils**
☐ **Trusts (along with any Amendments)**

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SECTION 3 – ASSETS/DEBTS/EXPENSES/GIFTS

I. Individual gross income

* We will need verification of income "from the source." Although income may be directly deposited into a bank account, we must have verification from the company or organization that generates the income. Bank Statements are not sufficient. ***NOTE: IF WE WILL BE APPLYING FOR MEDICAID FOR THIS INDIVIDUAL AND THEIR TOTAL GROSS MONTHLY INCOME MEETS OR EXCEEDS THE MAXIMUM ALLOWABLE INCOME FOR MEDICAID, A QUALIFIED INCOME TRUST MAY BE NEEDED.***

☐	**Social Security Statement**	☐	**VA Statement**
☐	**Pension statement**	☐	**IRA Statement**
☐	**Dividend statement**	☐	**Interest statement**
☐	**Trust statement**	☐	**All other**

NOTE: IF WE WILL BE APPLYING FOR MEDICAID FOR THIS INDIVIDUAL AND THEIR TOTAL GROSS MONTHLY INCOME MEETS OR EXCEEDS THE MAXIMUM ALLOWABLE INCOME FOR MEDICAID, A QUALIFIED INCOME TRUST MAY BE NEEDED.

II. Assets:

If asset has been closed within the last 5 years (including during this process) we will need verification of the disposal of these funds. We will need the final statement showing the value of the asset at the time of closure.

We will need the last three months statements **ALL** pages on **ALL** assets. We will need policies, titles and/or Deeds. If asset has been closed within the last 5 years (including during this process) we will need verification of the disposal of these funds. We will need the final statement showing the value of the asset at the time of closure. If we are working toward Medicaid or VA Aid and Attendance eligibility; we will require verification of all assets closed during this process; as well as, verification of where the proceeds were moved to. After the application has been submitted to the Department of Children and Families or Veteran's Administration, and until approval, we will need all ongoing statements. Note: some statements are sent quarterly; in this case the current and previous statements are needed.

- ☐ **Past 3 months statements for ALL assests**
- ☐ **Policies**
- ☐ **Deeds**
- ☐ **Motor Vehicle Title(s)**

III. Obligations

- ☐ **Mortgage, home equity line of credit, reverse mortgage…**
- ☐ **Credit card debt**
- ☐ **Loans**
- ☐ **Insurance premium payments** ☐ **Property taxes**

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IV. TRANSFERS/GIFTS Information

☐ **Proof of event and date of any repayment**

CERTIFICATION

The undersigned hereby represents to Keiber Senior Services that the information contained in this intake form is accurate and complete, and that the undersigned understands that Keiber Senior Services will rely on this information for the purposes of developing a Long Term Care Financial plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct and negative impact on Long Term Care Insurance, VA Aid and Attendance Pension or Medicaid eligibility.

Signature of Client or Client Representative:

_____ Date:_____

Once completed, please return this form to:
Keiber Senior Services
15701 HWY 50, Suite 204
Clermont, FL 34711
Phone: 352-404-4242
Facsimile: 877-294-8872
Email: Scott@KeiberSeniorServices.com