# A close up of a logo  Description generated with very high confidence

# **Pre-Planning Questionnaire**

**Today’s Date:** Click to enter a date.

**Client 1’s Name:** Click to enter text. **Client 2’s Name, if any:** Click to enter text.

**Client’s DOB:** Click to enter a date. **Age:** Age **Client 2’s DOB:** Click to enter a date. **Age:** Age

**Address:** Click to enter text.

**Home Phone:** Click to enter #. **Cell Phone:** Click to enter #. **Work phone:** Click to enter #.

**Client 1’s Email:** Click to enter text. **Client 2’s email:** Click to enter text.

**Marital Status:** Choose an item.

**Children’s Info, if applicable:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **DOB** | **Age** | **Whose child** |
|   | DOB |   | Choose an item. |
|   | DOB |   | Choose an item. |
|   | DOB |   | Choose an item. |
|   | DOB |   | Choose an item. |

**Pre-Screening Health Statement – Part A Client 1 Client 2, if any**

|  |  |  |
| --- | --- | --- |
| 1. Within the past two years have you been confined to a nursing home, assisted living center, received or been advised to receive hospice care, been advised that you have a terminal illness or need assistance with: bathing, eating, dressing, toileting, transferring into and out of bed, chair, or wheelchair and/or maintain continence?
 | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| 1. Are you currently hospitalized, bedridden or use medical devices such as: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair lift, chair lift, motorized scooter or taking medications Aricept, Exelon, Reminyl or Namenda?
 | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| 1. Have you ever been diagnosed by a member of the medical profession as having AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?
 | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |
| 1. If under the age of 65, is there any reason you are not physically and mentally capable of active employment or are you currently receiving or have received within the past five years social security disability income benefits?
 | [ ]  **Yes** [ ]  **No**[ ]  **N/A** | [ ]  **Yes** [ ]  **No** [ ]  **N/A** |
| 1. Have you ever been diagnosed, treated, tested positive for, or been given professional medical advice for: Alzheimer’s disease, dementia, memory loss, multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig’s disease) Parkinson’s disease, down syndrome, organ transplant (other than kidney) or active cancer?
 | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |

**Client(s) Pre-screening Health Statement – Part B**

**Client 1’s Name:** Click to enter text. **Height:** Click to enter text. **Weight:** Click to enter text.

**In the past 5 years, is there a history of:**

[ ] Diabetes [ ] Leukemia [ ] Heart Disease [ ] Heart Attack [ ] Stroke [ ] Depression

[ ] Congestive Heart Failure [ ] Cardiomyopathy [ ] Uncontrolled High Blood Pressure

[ ] Amyotrophic Lateral Sclerosis (ALS) [ ] Cancer [ ] Organ Failure/Disease [ ] Alcohol/Drug Abuse

[ ] Chronic Obstructive Lung Disease (COLD) [ ] Chronic Obstructive Pulmonary Disease (COPD)

**Other:** Click to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Reason** |
| Choose an item. | Click to enter text. | Choose an item. | Click to enter text. |

**Comments:** Click to enter text.

**Client 2’s Name:** Click to enter text. **Height:** Click to enter text. **Weight:** Click to enter text.

**In the past 5 years, is there a history of:**

[ ] Diabetes [ ] Leukemia [ ] Heart Disease [ ] Heart Attack [ ] Stroke [ ] Depression

[ ] Congestive Heart Failure [ ] Cardiomyopathy [ ] Uncontrolled High Blood Pressure

[ ] Amyotrophic Lateral Sclerosis (ALS) [ ] Cancer [ ] Organ Failure/Disease [ ] Alcohol/Drug Abuse

[ ] Chronic Obstructive Lung Disease (COLD) [ ] Chronic Obstructive Pulmonary Disease (COPD)

**Other:** Click to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Dose** | **Frequency** | **Reason** |
| Choose an item. | Click to enter text. | Choose an item. | Click to enter text. |

**Comments:** Click to enter text.

**Financial Information**

1. **Own home:** [ ]  **No** [ ]  **Yes** **If Yes, Value $**Click to enter text.

**Outstanding Mortgage:** [ ]  **No** [ ]  **Yes** **If Yes, Balance owed: $**Click to enter text.

**Mortgage interest rate:** Click to enter text.

**HELOC:** [ ]  **No** [ ]  **Yes If Yes, Balance owed: $**Click to enter text.

**Reverse Mortgage:** [ ]  **No** [ ]  **Yes**

Please add any monthly mortgage payment to Monthly Expenses section below.

1. **Own other property/real estate?** [ ]  **No** [ ]  **Yes** **Description:** Click to enter text.

**Value $** Click to enter text. **Outstanding Mortgage $** Click to enter text.

1. **Monthly Income (Gross amounts)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type** | **Client 1** | **Client 2** | **Notes** |
| Choose an item. | Click to enter text. | Click to enter text. | Click to enter text. |
| Choose an item. | Click to enter text. | Click to enter text. | Click to enter text. |
| Choose an item. | Click to enter text. | Click to enter text. | Click to enter text. |
| Choose an item. | Click to enter text. | Click to enter text. | Click to enter text. |
| Choose an item. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Total** | 0 | 0 | 0 |
| **Are you retired?** | [ ]  **Yes** [ ]  **No** | [ ]  **Yes** [ ]  **No** |  |

**Do you rely on IRA income for living expenses?** [ ]  **Yes** [ ]  **No**

**If you are not retired, provide estimated Social Security benefit/month at:**

* **full retirement age $**Click to enter text.
* **early retirement age $**Click to enter text.
* **late retirement age $**Click to enter text.

 **Federal Income Tax Bracket:** Choose an item. **AGI on most recent tax return: $**Click to enter text.*See 2018 Federal Tax Rates table at end.*

1. **Monthly Expenses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type** | **Client 1’s** | **Client 2’s** | **Notes** |
| Health Insurance monthly premium |  |  | Not including any Medicare part B premiums |
| Choose an item. | Click to enter text. | Click to enter text. | Click to enter text. |
| Choose an item. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Total** | 0 | 0 |  |

**Other liabilities (like credit card debt, student loans, personal loans)** [ ]  **No** [ ]  **Yes** **If Yes, combined balance $** Click to enter text.

**Are you making contributions to an IRA or 401k?** [ ]  **No** [ ]  **Yes** **If yes, how much and how often:** Click to enter text.

1. **Assets**

|  |  |  |
| --- | --- | --- |
| **Accounts** | **Owner of account** | **Value of account** |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. |
| **Total** |  | 0 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Life insurance****Company and Policy #** | **Owner** | **Death Benefit** | **Cash Value** | **Year Issued** |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. | Click to enter text. |
| **Total** |  | 0 | 0 | 0 |

**Clients Goals and Objectives**

1. **Is there a Long-term Care Insurance Plan in place?** [ ]  **Yes** [ ]  **No**

**Total Benefit Amount: $**Click to enter text. **Daily Benefit Amount: $**Click to enter text. **Premium: $**Click to enter text. **How many rate increases have you experienced?** Click to enter text.

1. **If you get sick and need LTC, where would you want to receive care?**

 [ ]  **At home** [ ]  **Assisted Living** [ ]  **Nursing Home**

1. **Assuming you need LTC, which asset would you liquidate first to pay for care?** Choose an item.
2. **Have you been declined for any type of insurance in past 5 years?** [ ]  **Yes** [ ]  **No**

**If yes, explain** Click to enter text.

1. **Is there anyone in your family (adult child, grandchild) with a special needs disability?**

 [ ]  **Yes** [ ]  **No**

1. **Please tell us what you are hoping to accomplish for your client with this plan?**

Click to enter text.

1. **Are there any special circumstances we should be aware of as we design this plan, e.g. client likes, dislikes, or any factors we should be aware of that will make this plan the perfect one for your clients?**

Click to enter text.

**Who is the primary contact in your office in case we have any questions about this fact find?** Choose an item.

**What is the best way to reach him/her?** [ ]  **Phone:** Choose an item.

 [ ]  **Email:** Choose an item.

 [ ]  **Cell Phone:** Click to enter text.

**Date of next appointment:** Click or tap to enter a date.

