Client Fact Find

Today's Date: ____________________

Name: ____________________ Spouse, if married: ____________________

Date of Birth: ____________ Spouse's DOB: ____________

Address: ____

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Email: ____________________

1. **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced
2. **Currently in need of care?** ☐ Yes ☐ No **If so, when?** ____________________

   If so, who? ____________________

   Type of care

   ☐ Skilled/Nursing Home ☐ Living Independently

   ☐ Living with family/friends ☐ Assisted Living

   Relationship

   ☐ Mother ☐ Father

   ☐ Spouse ☐ Other

3. **If receiving care in a Nursing Home, date entered the care facility?** ____________________

   Name of Facility: ____________________

   Current Address if different from above (whether in a facility or not): ☐ **Same as above**

   ____

   ____

   Monthly Cost of Care $ ____________

   ☐ Private Room

   ☐ Semi-Private Room

   ☐ Does the facility have Medicaid beds? ☐ Yes ☐ No ☐ Unknown

4a. **Is there a Long-Term Care Insurance Plan in place?** ☐ Yes ☐ No

   If yes, who owns the policy? ____________________

   If yes, is it a Partnertship Plan? ☐ Yes ☐ No

   If so, name of Insurance Company: ____________________

   Daily/Monthly Benefit $ ____________ **Benefit Period:** ____________

4b. **If you get sick and need LTC, where would you want to receive care?**

   ☐ At home ☐ Assisted Living ☐ Nursing Home

   Assuming you need LTC, which asset would you liquidate first to pay for care?

   ☐ Checking/Savings ☐ IRA ☐ Annuities ☐ Stocks/Bonds/Mutual Funds

5. **Children's Names/Age** (if any):

Name	DOB

Pre-Screening Health Statement - Part A

	Client	Spouse (if applicable)
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
2. 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
3. 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
4. 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	☐ Yes ☐ No
5. 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 Pre-Screening Health Statement - Part B

Client: ___________________________

1. **Check all activities of daily living that require assistance or supervision:**
   ☐ Bathing ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating ☐ Continence
   Comments: ___________________________
   ____

2. **Height:** ______________ **Weight:** ______________

3. **Medications:**

Medication	Dose	Frequency	Reason

4. **Is there a history of:**
   ☐ Diabetes (If YES, please fill out the Diabetes questionnaire)
   ☐ Depression (If YES, please fill out the Depression questionnaire)
   ☐ Coronary Artery Disease (If YES, please fill out the Coronary Artery Disease questionnaire)
   ☐ Cancer (If YES, please fill out the Cancer questionnaire)
   ☐ Chronic Obstructive Pulmonary Disease (COPD) (If YES, please fill out the COPD questionnaire)
   Other: ___________________________

5. **Comments:** ___________________________
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

Spouse Pre-Screening Health Statement - Part B

Spouse: ______________________________

1. **Check all activities of daily living that require assistance or supervision:**

   ☐ Bathing ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating ☐ Continence

   Comments: ______________________________

2. **Height:** ____________ **Weight:** ____________

3. **Medications:**

Medication	Dose	Frequency	Reason

4. **Is there a history of:**

   ☐ Diabetes (If YES, please fill out the Diabetes questionnaire)

   ☐ Depression (If YES, please fill out the Depression questionnaire)

   ☐ Coronary Artery Disease (If YES, please fill out the Coronary Artery Disease questionnaire)

   ☐ Cancer (If YES, please fill out the Cancer questionnaire)

   ☐ Chronic Obstructive Pulmonary Disease (COPD) (If YES, please fill out the COPD questionnaire)

   Other: ______________________________

5. **Comments:** ______________________________

Financial Information

1. **Own Home?** ☐ Yes ☐ No **Value $** ____________________
2. **Outstanding Mortgage $** ____________ **Cost Basis $** ____________
3. **Principal and interest payments $** ____________ **Taxes/Insurance payment $** ____________
4. **Own other property/real estate?** ☐ Yes ☐ No **Description:** ____________
   Value $ ____________ **Mortgage $** ____________ **Cost Basis $** ____________
5. **Monthly Income:**

Type	Client Income	Spouse Income
Social Security		
Gross Wages		
Pensions		
Spousal Pension Continuation Benefit		
Military Retirement		
Interest/Dividends		
Investment Property		
Income from IRA's		
Other		
Other		
TOTAL		

6. **Do you rely on IRA Income for living expenses?** ☐ Yes ☐ No
7. **Monthly Expenses:**

Type	Client Income	Spouse Income
Medicare Part B		
Medicare Part C &/or D		
Private Med. Insurance		
Prescriptions		
Home Care/AL/NH		
Incontinence Supplies		
Other		
Other		
Other		
Other		
TOTAL		

8. Assets:

Checking/Savings Acct.	Owner of Acct.	Value of Acct.
TOTAL		

C.D.'s/Money Markets	Owner of Acct.	Value of Acct.
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TOTAL		

Stocks/Bonds	Owner	Value of Acct.	Cost Basis
TOTAL			

Annuities	Owner	Value	Cost Basis	Surrender Value
TOTAL				

Mutual Funds	Owner	Value of Acct.	Cost Basis
TOTAL			

Qualified Accounts	Owner	Investment Type	Value of Acct.	Surrender Value
TOTAL				

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Other/Cash Value Life Ins.	Owner	Death Benefit	Cash Value	Cash Surrender Value
TOTAL				

Total Countable Assets $ ____________________

9. Have any gifts been made? ☐ Yes ☐ No If so, when? ____________________

10. Amount of Gift $ ____________________

11. To whom was gift made? ____________________

Please tell us what you are hoping for your client with this plan? ____________________

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 fit for your clients?

Legal Information

1. Is there a Durable Power of Attorney in place? ☐ Yes ☐ No
   If so, who is listed as the POA? ______________________________
   ____
2. Is there a Will in place? ☐ Yes ☐ No
3. Is there a Trust? ☐ Yes ☐ No Name of Trust: ______________________________
   Is the Trust ☐ Revocable ☐ Irrevocable Tax ID# of Trust: ______________________________
4. Is there a prepaid burial/funeral plan in place? ☐ Yes ☐ No If so, $ ______________

Comments/Notes: ______________________________

IMPORTANT: This Section Must Be Completed

Agent Contact Information

Firm: ______________________________

Address: ______________________________
____

Email: ______________________________

Phone: ______________________ Fax: ______________________

Diabetes Questionnaire

Your Name: ______________________________

1. Approximate date first diagnosed: ______________
2. How often do you visit your physician? ______________________________

   ____
3. My diabetes is controlled by:
   - ☐ Diet alone
   - ☐ Oral medication (medication and doses) ______________________________
   - ☐ Insulin (amount and units/day) ______________________________
4. Please give the most recent glucose blood sugar reading: ______________________________

   ____
5. Do you monitor your own blood sugar? ☐ Yes ☐ No
6. Please give your most recent A1c reading: ______________________________
7. Please check if you have (had) any of the following:

   ☐ Chest pain or coronary artery disease ☐ Protein in the urine ☐ Elevated lipids ☐ Overweight

   ☐ Neuropathy ☐ Kidney disease ☐ Retinopathy ☐ Abnormal ECG ☐ Hypertension

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Depression Questionnaire

Your Name: ______________________________

1. List the diagnosis: ______________________________

____

____

2. Please indicate:

   Number of episodes: ____________ Date of last episode: ____________

3. Are you on any medications? ☐ Yes ☐ No

   If yes, give accurate name, dosage, and reason: ______________________________

____

____

____

____

4. Have you been diagnosed for psychiatric treatment? ☐ Yes ☐ No

   If yes, give dates and lengths of stay: ______________________________

____

____

5. Do you have a history of any of the following associated conditions? (Check all that apply):

   ☐ Personality disorder
   ☐ Psychotic disorder
   ☐ Suicidal thoughts/attempts
   ☐ Substance abuse (alcohol or drugs) [Complete questionnaire]
   ☐ Other psychiatric disorder

6. Are you currently working? (Occupation): ______________________________

____

7. Has any time been lost from work as a result of condition? ☐ Yes ☐ No

   If yes, give details: ______________________________

____

____

____

____

____

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Coronary Artery Questionnaire

Your Name: ______________________________

1. List approximate date(s) of diagnosis and type of coronary artery disease:

____

____

2. Do you have a family history of heart disease? ☐ Yes ☐ No

   If yes, list family member and details: ______________________________

____

____

3. Have you had any of the following?:

☐ Heart attack Date: ______________

☐ Coronary angioplasty (PTCA) Date: ______________

☐ Heart failure Date: ______________

☐ Valve Surgery Date: ______________

☐ Bypass Surgery Date: ______________

4. Please check if you have (had) any of the following:

☐ Abnormal lipid levels ☐ Diabetes ☐ Overweight ☐ Elevated homocysteine

☐ High blood pressure ☐ Peripheral vascular disease ☐ Irregular heart beats

☐ Cerebrovascular or carotid disease ☐ Elevated cholesterol

5. Are you on any medications? ☐ Yes ☐ No

   If yes, give accurate name, dosage, and reason: ______________________________

____

____

____

____

____

Cancer Questionnaire

Your Name: ______________________

1. What type of cancer was diagnosed? ______________________

2. List approximate date of first diagnosis: ______________
3. Is there a family history of cancer? ☐ Yes ☐ No
   If yes, give details: ______________________

4. How was the cancer treated?
   ☐ Surgery ☐ Chemotherapy ☐ Radiation therapy ☐ Hormonal therapy
   ☐ Immunotherapy ☐ Other (give full details) ______________________

5. List date treatment was completed: ______________
6. What was the stage and grade of the cancer? ______________________

7. Has there been any evidence of reoccurrence? ☐ Yes ☐ No
   If yes, give details: ______________________

8. What did the pathology report reveal? ______________________

9. Are you on any medications? ☐ Yes ☐ No
   If yes, give accurate name, dosage, and reason: ______________________

Chronic Obstructive Pulmonary Disease (COPD) Questionnaire

Your Name: ______________________

1. **What is the type of lung disease?**
   ☐ Chronic bronchitis ☐ Emphysema ☐ Restrictive lung disease ☐ Asthma
2. **Please list approximate date when first diagnosed:** ______________
3. **Have you ever been hospitalized for this condition?** ☐ Yes ☐ No
   If yes, give details: ______________________
4. **Have you ever smoked?**
   ☐ Yes, and currently smoke ______________ (amount/day)
   ☐ Yes, smoked in the past but quit ______________ (date)
   ☐ Never smoked
5. **Are you on any medications?** ☐ Yes ☐ No
   If yes, give accurate name, dosage, and reason; include inhalers: ______________________
6. **Have pulmonary function tests (a breathing test) ever been done?** ☐ Yes ☐ No
   If yes, give most recent test results: ______________________
7. **What is your Height?** ______________ **Weight?** ______________
8. **Do you have any abnormalities on an ECG or X-ray?** ☐ Yes ☐ No
   If yes, give details: ______________________

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