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CONFIDENTIAL
LIFETIME PLANNING INTAKE FORM

We recommend you fill out this form using Adobe Acrobat Reader. The goal of our initial meeting is to get acquainted, for us to assess your situation to determine if and how we are able to assist you, and to then explain the relevant fees for the legal services, if any, that are appropriate for your situation. The information gathered by this intake form is essential to achieve the above goals. Pages 1-7 of this form are required except where it is indicated that the information is optional. Page 8 is optional. Pages 9-14 are needed only for potential clients who are over age 65 and/or have significant health problems. When done, please provide this form to the office at least 48 hours before your introductory meeting, preferably via email.

Married Couples: Please initial the lines below if you are a married couple to acknowledge that we must reveal to both clients all information shared with us by either client: _____ | _____

Fragrance-Free Office: We are a fragrance-free office because several of our staff are sensitive to the chemicals found in perfumes, baby powders, bath powders, colognes, aftershaves, hair spray, and scented body lotions. These chemicals can cause serious problems for people with asthma, allergies, and environmental illnesses. Scented soaps and deodorants are okay, but we must insist that you refrain from wearing other scented products to our office. Thank you!

How to Prepare: If you haven't already, please be sure to read through our Four Levels of Planning for Lifetime Protection before your meeting; it's on our website under Forms.

Who Should Participate: For potential Level 4 Matters, all family decision-makers should be part of the introductory consultation. This may be just the elder(s)/client(s), but often it includes the adult children or agents under power of attorney for the elders. For potential Level 1, 2, or 3 Matters, the actual clients seeking to plan their estates should be present; if desired, additional family members, trusted friends, and financial advisors are welcome to attend the introductory meeting, but the planning session, done after the introductory meeting, must be a private meeting between the attorney and the client(s).

What to Provide: Please provide as many of the following documents as possible at, or preferably before, your introductory meeting:

- Any existing estate planning documents (powers of attorney, trusts, wills, etc);
- Any existing long-term care insurance policies;
- Deeds for all real estate you own;
- Any life insurance policies or annuities you own;
- Recent statements from your financial accounts.

How Did You Hear About the Farr Law Firm? _____

NAME(S) OF PERSON(S) COMPLETING THIS FORM:

1. Name: _____ ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. Relationship to Client(s): _____ Email: _____ Primary Contact Person? ☐ Yes ☐ No	2. Name: _____ ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. Relationship to Client(s): _____ Email: _____ Primary Contact Person? ☐ Yes ☐ No

Personal Information About Client(s)

These questions pertain to the elder or elders for whom we are planning, regardless of who is completing this form. For single clients, complete left side only; for couples, complete both sides.

Name: _____ ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms.	Name: _____ ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms.
Main Phone: _____ May we leave you messages? ☐ Yes ☐ No	Main Phone: _____ May we leave you messages? ☐ Yes ☐ No
Cell Phone: _____ May we leave you messages? ☐ Yes ☐ No	Cell Phone: _____ May we leave you messages? ☐ Yes ☐ No
Home Address: _____ _____	Home Address: _____ _____
Home Phone: _____ May we leave you messages? ☐ Yes ☐ No	Home Phone: _____ May we leave you messages? ☐ Yes ☐ No
Email Address: _____ May we communicate with you via email? ☐ Yes ☐ No	Email Address: _____ May we communicate with you via email? ☐ Yes ☐ No
Name of Business/Employer: _____ Work Address: _____ _____	Name of Business/Employer: _____ Work Address: _____ _____
Occupation: _____ Former Occupation if Retired: _____	Occupation: _____ Former Occupation if Retired: _____
Place of Birth: _____	Place of Birth: _____
Date of Birth: _____	Date of Birth: _____
Age: _____	Age: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Date of Marriage: _____ Place of Marriage: _____ Name of current spouse: _____ Prior spouse(s): Name: _____ ☐ Divorced ☐ Deceased - date: _____ Name: _____ ☐ Divorced ☐ Deceased - date: _____ Name: _____ ☐ Divorced ☐ Deceased - date: _____	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Date of Marriage: _____ Place of Marriage: _____ Name of current spouse: _____ Prior spouse(s): Name: _____ ☐ Divorced ☐ Deceased - date: _____ Name: _____ ☐ Divorced ☐ Deceased - date: _____ Name: _____ ☐ Divorced ☐ Deceased - date: _____

Do you have any dependents (that is, someone who depends on you, in whole or in part, for their support)?
☐ No ☐ Yes If yes, who: _____

Do you have any children who are disabled? ☐ No ☐ Yes If yes, who: _____

If yes, does any such child receive any of the following benefits: ☐ SSDI ☐ SSI ☐ Medicaid

Have you ever used any other name? ☐ Yes ☐ No If yes, what name?_____ When used?_____	Have you ever used any other name? ☐ Yes ☐ No If yes, what name?_____ When used?_____
Existing prepaid funeral arrangements? ☐ Yes ☐ No Existing cemetery plot? ☐ Yes ☐ No	Existing funeral arrangements? ☐ Yes ☐ No Existing cemetery plot? ☐ Yes ☐ No
Do you provide care to an aging parent? ☐ Yes ☐ No	Do you provide care to an aging parent? ☐ Yes ☐ No
Do you provide financial assistance to a child? ☐ Yes ☐ No	Do you provide financial assistance to a child? ☐ Yes ☐ No
Do you provide financial assistance to a sibling? ☐ Yes ☐ No	Do you provide financial assistance to a sibling? ☐ Yes ☐ No
Asset Protection Goals (if any): There are two reasons to protect assets; either to improve the quality of your own care when needed in the future or to preserve an inheritance for your children. Please check one box below to rate the relative importance of these two reasons. Picking 1: It is extremely important to you to get the best possible care. Picking 5: It is extremely important to you to leave inheritance. 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Protect Assets to Enhance Your Long-term Care — Protect Assets to Preserve Inheritance	**Asset Protection Goals (if any):** There are two reasons to protect assets; either to improve the quality of your own care when needed in the future or to preserve inheritance for your children. Please check one box below to rate the relative importance of these two reasons. Picking 1: It is extremely important to you to get the best possible care. Picking 5: It is extremely important to you to leave inheritance. 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Protect Assets to Enhance Your Long-term Care — Protect Assets to Preserve Inheritance
Do you have any of the following legal documents? Last Will and Testament ☐ No ☐ Yes, dated: _____ Revocable Living Trust ☐ No ☐ Yes, dated: _____ Living Will ☐ No ☐ Yes, dated: _____ Health Care POA ☐ No ☐ Yes, dated: _____ Durable Financial POA ☐ No ☐ Yes, dated: _____ Other: _____ ☐ No ☐ Yes, dated: _____	Do you have any of the following legal documents? Last Will and Testament ☐ No ☐ Yes, dated: _____ Revocable Living Trust ☐ No ☐ Yes, dated: _____ Living Will ☐ No ☐ Yes, dated: _____ Health Care POA ☐ No ☐ Yes, dated: _____ Durable Financial POA ☐ No ☐ Yes, dated: _____ Other: _____ ☐ No ☐ Yes, dated: _____
Are you a citizen of the United States? ☐ Yes ☐ No	Are you a citizen of the United States? ☐ Yes ☐ No
Are you a Military Veteran? ☐ Yes ☐ No If yes, were you active duty during wartime? ☐ Yes ☐ No If yes, please give dates of service: _____ If you are widowed, please fill out spouse section here >>>>>>>>>>>	Are you a Military Veteran? ☐ Yes ☐ No If yes, were you active duty during wartime? ☐ Yes ☐ No If yes, please give dates of service: _____

Name and Contact Information of Personal Advisors: (Helpful but Not Required)		**Name and Contact Information of Personal Advisors: (Helpful but Not Required)**	
Tax Accountant	Name: _____ Phone: _____ Email: _____ May we talk to this person about you if needed? ☐ Yes ☐ No	Tax Accountant	Name: _____ Phone: _____ Email: _____ May we talk to this person about you if needed? ☐ Yes ☐ No
Financial Planner	Name: _____ Phone: _____ Email: _____ May we talk to this person about you if needed? ☐ Yes ☐ No	Financial Planner	Name: _____ Phone: _____ Email: _____ May we talk to this person about you if needed? ☐ Yes ☐ No
Life Insurance Agent	Name: _____ Phone: _____ Email: _____ May we talk to this person about you if needed? ☐ Yes ☐ No	Life Insurance Agent	Name: _____ Phone: _____ Email: _____ May we talk to this person about you if needed? ☐ Yes ☐ No

Comprehensive Contact Information

Using the next two pages (and, if necessary additional sheets), please identify **all** of your children, including any deceased children and any children you plan to disinherit. Also identify all other individuals whom you may be naming either as beneficiaries or decision makers (i.e., executors, trustees, or agents under a power of attorney). Please be sure to provide each person's relationship to you. If you provide an email address, please note that person will automatically get an invitation to sign up for our newsletter. For any information that's the same for Client 2 as for Client 1, just write "same."

Client 1:	Client 2:
1. Name:	1. Name:
Relationship: Age:	Relationship: Age:
Occupation:	Occupation:
Email:	Email:
Street Address:	Street Address:
City/St/Zip:	City/St/Zip:
Mobile Phone:	Mobile Phone:
Home Phone:	Home Phone:
Spouse Name: Age:	Spouse Name: Age:
Number of children:	Number of children:
May we talk to this person about you if needed? ☐ Yes ☐ No	May we talk to this person about you if needed? ☐ Yes ☐ No
2. Name:	2. Name:
Relationship: Age:	Relationship: Age:
Occupation:	Occupation:
Email:	Email:
Street Address:	Street Address:
City/St/Zip:	City/St/Zip:
Mobile Phone:	Mobile Phone:
Home Phone:	Home Phone:
Spouse Name: Age:	Spouse Name: Age:
Number of children:	Number of children:
May we talk to this person about you if needed? ☐ Yes ☐ No	May we talk to this person about you if needed? ☐ Yes ☐ No
3. Name:	3. Name:
Relationship: Age:	Relationship: Age:
Occupation:	Occupation:
Email:	Email:
Street Address:	Street Address:
City/St/Zip:	City/St/Zip:
Mobile Phone:	Mobile Phone:
Home Phone:	Home Phone:
Spouse Name: Age:	Spouse Name: Age:
Number of children:	Number of children:
May we talk to this person about you if needed? ☐ Yes ☐ No	May we talk to this person about you if needed? ☐ Yes ☐ No

Client 1 - Number of Living Parents:	Client 2 - Number of Living Parents:
Client 1 - Number of Living Siblings:	Client 2 - Number of Living Siblings:
Client 1 - Number of Deceased Siblings:	Client 2 - Number of Deceased Siblings:

4. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

4. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

5. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

5. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

6. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

6. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

7. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

7. Name:
Relationship: Age:
Occupation:
Email:
Street Address:
City/St/Zip:
Mobile Phone:
Home Phone:
Spouse Name: Age:
Number of children:
May we talk to this person about you if needed? Yes No

Financial Information

Monthly Income:

Type	Client 1 Income	Client 2 Income
Social Security		
Pensions		
Spousal Pension Continuation Benefit		
Military Retirement		
Gross Earnings from Employment		
Interest/Dividends		
Investment Real Estate		
Distributions from IRA's		
Other		
Total	$0.00	$0.00

Do you need IRA funds for living expenses? ☐ Yes ☐ No **Do you anticipate any inheritance?** ☐ Yes ☐ No
If yes, how much? $

Real Estate:

Own Home? ☐ Yes ☐ No Value $ Owned as: Please Select
Outstanding Mortgage $ HELOC Amt. Borrowed: $ Amt. Available $
Own other property/real estate? ☐ Yes ☐ No City / State: Owned as: Please Select
Value $ Mortgage $ Check this box ☐ if additional realty and attach a list.

Financial Assets:

Checking/Savings/CDs/Money Markets	Type of Acct	Owner of Account	Value of Account
Enter Name of Bank	Please Select		
Enter Name of Bank	Please Select		
Enter Name of Bank	Please Select		
Enter Name of Bank	Please Select		
Enter Name of Bank	Please Select		
		TOTAL	$0.00

Individual Stocks/Bonds/Treasuries	Type of Acct	Owner of Account	Current Value
Enter Name of Bank or Government E	Please Select		
Enter Name of Bank or Government E	Please Select		
Enter Name of Bank or Government E	Please Select		
Enter Name of Bank or Government E	Please Select		
Enter Name of Bank or Government E	Please Select		
		TOTAL	$0.00

Brokerage Accts (non IRA)	Owner	Beneficiary(ies) if any	Current Value
Name of Management or Brok			
Name of Management or Brok			
Name of Management or Brok			
Name of Management or Brok			
Name of Management or Brok			
		TOTAL	$0.00

Cash Value Annuities	Owner	Beneficiary(ies) if any	Pre-Tax or After-Tax	Current Value
Name of Insurance Co			Please Select	
Name of Insurance Co			Please Select	
Name of Insurance Co			Please Select	
Name of Insurance Co			Please Select	
Name of Insurance Co			Please Select	
			TOTAL	$0.00

Mutual Funds	Owner	Beneficiary(ies) if any	Current Value
Name of Fund Company			
Name of Fund Company			
Name of Fund Company			
Name of Fund Company			
Name of Fund Company			
		TOTAL	$0.00

IRA (Including Roth)	Owner	Traditional or Roth?	Beneficiary(ies) if any	Current Value
Name of IRA Custodia		Please Select		
Name of IRA Custodia		Please Select		
Name of IRA Custodia		Please Select		
Name of IRA Custodia		Please Select		
Name of IRA Custodia		Please Select		
			TOTAL	$0.00

401k/403b/TSP, etc.	Owner	Type of Account	Beneficiary(ies) if any	Current Value
Name of Account Cus		Please Select		
Name of Account Cus		Please Select		
Name of Account Cus		Please Select		
Name of Account Cus		Please Select		
			TOTAL	$0.00

Owner of above accounts still working? ☐ Yes ☐ No

Insurance Policies (Life/Home/Auto/Umbrella)

Insurance Company Name	Type of Policy	Maximum Liability Limit	Life Ins. Death Benefit	Life Ins. Cash Value
Name of Insurance Co	Please Select			
Name of Insurance Co	Please Select			
Name of Insurance Co	Please Select			
Name of Insurance Co	Please Select			
Name of Insurance Co	Please Select			
Name of Insurance Co	Please Select			
		TOTAL	$ 0.00	$0.00

Existing Long-Term Care (LTC) Planning

Do you have Long-Term Care Insurance in place? ☐ Yes ☐ No

If yes, please provide the details of your LTC insurance policy.	**Name of Company:** **Daily Benefit Amount @Facility:** **Daily Benefit Amount @Home:** **Lifetime Benefit Amount:** **Annual Premium:** **Has Your Premium Increased?** ☐ Yes ☐ No
If you do not have any LTC insurance, check all applicable boxes.	☐ Have you looked into LTC coverage? ☐ Have you applied for traditional LTC insurance? ☐ Have you applied for hybrid LTC insurance? ☐ Are you interested in getting LTC Coverage? ☐ Reverse mortgage if needed to pay for LTC? ☐ Need advice on how to best pay for LTC?
Check all boxes applicable for if and when you need LTC assistance.	☐ Age in Place as Long as Possible? ☐ Live with Family Member When Needed? ☐ Family Member Move in With You? ☐ Continuing Care Retirement Community? ☐ Assisted Living / Memory Care? ☐ Avoid Nursing Home if Possible?

Do you have Long-Term Care Insurance in place? ☐ Yes ☐ No

If yes, please provide the details of your LTC insurance policy	**Name of Company:** **Daily Benefit Amount @Facility:** **Daily Benefit Amount @Home:** **Lifetime Benefit Amount:** **Annual Premium:** **Has Your Premium Increased?** ☐ Yes ☐ No
If you do not have any LTC insurance, check all applicable boxes.	☐ Have you looked into LTC coverage? ☐ Have you applied for traditional LTC insurance? ☐ Have you applied for hybrid LTC insurance? ☐ Are you interested in getting LTC Coverage? ☐ Reverse mortgage if needed to pay for LTC? ☐ Need advice on how to best pay for LTC?
Check all boxes applicable for if and when you need LTC assistance.	☐ Age in Place as Long as Possible? ☐ Live with Family Member When Needed? ☐ Family Member Move in With You? ☐ Continuing Care Retirement Community? ☐ Assisted Living / Memory Care? ☐ Avoid Nursing Home if Possible?

Financial Decision-Makers - Helpful but Not Required

Person(s) You Wish to Name as Agent(s) under Power of Attorney, Executor, and Trustee:

This is a list of persons, in sequential order, you want to be responsible for paying your bills and managing your legal and financial affairs, both while you're alive (if you become incapacitated), and after your death. Please try to give at least two choices, in case your first choice is unable or unwilling to act. You can indicate if you want two people as co-decision-makers, both of whom can act separately; be sure these people tend to agree so they don't wind up in court. These are not final decisions, as all of your choices will need to be confirmed during your private Planning Session.
The people listed here should be listed above in the section titled "Comprehensive Contact Information."

Client 1 - First Choice:		**Client 2 - First Choice:**	
Client 1 - Second Choice:		**Client 2 - Second Choice:**	
☐ Please check this box if you want the two people named above to be co-decision-makers, both of whom can act separately.		☐ Please check this box if you want the two people named above to be co-decision-makers, both of whom can act separately.	

If you want to name additional financial decision-makers, please list them.

Client 1 – Third Choice:		**Client 2 - Third Choice:**	
Client 1 – Fourth Choice:		**Client 2 – Fourth Choice:**	

Medical Decision-Makers - Helpful but Not Required

Person(s) You Wish to Name as Agent(s) under Your Medical Power of Attorney:

This is a list of persons, in sequential order, you want to be responsible for making health care decisions for you if you're unable to make such decisions for yourself. Please try to give at least two choices, in case your first choice is unable or unwilling to act. You can also indicate if you want two people who can both act independently or two people who must act jointly, but be sure these people tend to agree so they don't wind up in court. These are not final decisions, as all of your choices will need to be confirmed during your private Planning Session.
The people listed here should be listed above in the section titled "Comprehensive Contact Information."

Client 1 - First Choice:		**Client 2 - First Choice:**	
Client 1 - Second Choice:		**Client 2 - Second Choice:**	
☐ Please check this box if you want the two people named above to be co-decision-makers.		☐ Please check this box if you want the two people named above to be co-decision-makers.	

If you have additional medical decision-makers, please list them.

Client 1 – Third Choice:		**Client 2 - Third Choice:**	
Client 1 – Fourth Choice:		**Client 2 – Fourth Choice:**	

The Remainder of this Form is Very Helpful, But Required Only if a Client is Over Age 65 or Unhealthy

The remainder of this form is needed only for those over 65 and/or with significant health problems.

Client 1 - Please Complete this Page About Your Health

In the past 10 years, have you had a history of:

☐ Heart Attack ☐ Stroke ☐ DVT/PE ☐ Cancer ☐ Multiple Sclerosis ☐ Alcohol Abuse
☐ Drug Abuse ☐ Tobacco Use ☐ Autoimmune Condition(s): _____

Please indicate any current conditions:

☐ Hearing Loss ☐ Vision Loss ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ COPD
☐ Alzheimer's ☐ Vascular Dementia ☐ LBD ☐ FTD ☐ Other Dementia ☐ Parkinson's
☐ ALS ☐ Depression ☐ Asthma ☐ Alcohol Abuse ☐ Drug Abuse
☐ Organ Disease ☐ Organ Failure ☐ Congestive Heart Failure ☐ Uncontrolled High Blood Pressure
☐ Other Chronic Illnesses: _____

If your family has a history of needing long-term care at home or in a facility, please describe:

Place Where You Live		Since When?
☐	Single-family home or Town Home	
☐	Same, but someone assists you there with above activities	
☐	Apartment in retirement living community	
☐	Assisted Living Facility	
☐	Other:	
☐	Nursing Home:	

List the name(s) of any person(s) or agency providing assistance or caregiving for you:

How many hours per day, from whom, and on which days, are you receiving care:

Do you have prepaid funeral arrangements? ☐ Yes ☐ No
If yes, please indicate the name of the funeral home: _____

Do you own a cemetary plot or columbarium niche? ☐ Yes ☐ No
If yes, please indicate the name of the cemetery or memorial park: _____

Client 2 - Please Complete this Page About Your Health

In the past 10 years, have you had a history of:

☐ Heart Attack ☐ Stroke ☐ DVT/PE ☐ Cancer ☐ Multiple Sclerosis ☐ Alcohol Abuse
☐ Drug Abuse ☐ Tobacco Use ☐ Autoimmune Condition(s):_____

Please indicate any current conditions:

☐ Hearing Loss ☐ Vision Loss ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ COPD
☐ Alzheimer's ☐ Vascular Dementia ☐ LBD ☐ FTD ☐ Other Dementia ☐Parkinson's
☐ ALS ☐ Depression ☐ Asthma ☐ Alcohol Abuse ☐Drug Abuse
☐ Organ Disease ☐ Organ Failure ☐ Congestive Heart Failure ☐ Uncontrolled High Blood Pressure
☐ Other Chronic Illnesses: _____

If your family has a history of needing long-term care at home or in a facility, please describe:

Place Where You Live		**Since When ?**
☐	Single-family home or Town Home	
☐	Same, but someone assists you there with above activities	
☐	Apartment in retirement living community	
☐	Assisted Living Facility	
☐	Other:	
☐	Nursing Home:	

List the name(s) of any person(s) or agency providing assistance or caregiving for you:

How many hours per day, from whom, and on which days, are you receiving care:

Do you have prepaid funeral arrangements? ☐ Yes ☐ No
If yes, please indicate the name of the funeral home: _____

Do you own a cemetary plot or columbarium niche? ☐ Yes ☐ No
If yes, please indicate the name of the cemetery or memorial park: _____

Client 1 - If Over Age 65 or Unhealthy, Please Complete this Functional Capacity Evaluation:

The table below will help us understand the current level of care, if any, that is needed by Client 1.

Functional Capacity Evaluation

Activity	Needs No Help	Mechanical Help Only	Human Help		Mechanical Help and Human Help		Performed by Others		
			Supervision	Physical Assistance	Supervision	Physical Assistance			
Bathing									
Dressing									
Using the Toilet									
Transferring									
							Spoon Fed	Tube Fed	IV Fed
Feeding Self									

Continence	Needs No Help	Occasional Incontinence	Frequent Incontinence	External Device / Indwelling / Ostomy (Self Care)	External Device (Not Self Care)	Indwelling Catheter (Not Self Care)	Ostomy (Not Self Care)
Bowel							
Bladder							

Ambulation	Needs No Help	Mechanical Help Only	Human Help		Mechanical Help and Human Help		Performed by Others
			Supervision	Physical Assistance	Supervision	Physical Assistance	
Walking							
Wheeling							
Stair-climbing							
	Able to Move About at Home			Not Able to Move About			
If Homebound							

Activity	Needs Help?	
	Yes	No
Meal Preparation		
Housekeeping		
Laundry		
Managing Money		
Transportation		

Activity	Needs Help?	
	Yes	No
Shopping		
Using Phone		
Yard Care		
Pet Care		
Grooming		

Client 2 - If Over Age 65 or Unhealthy, Please Complete this Functional Capacity Evaluation:

The table below will help us understand the current level of care, if any, that is needed by Client 2.

Functional Capacity Evaluation

Activity	Needs No Help	Mechanical Help Only	Human Help		Mechanical Help and Human Help		Performed by Others		
			Supervision	Physical Assistance	Supervision	Physical Assistance			
Bathing									
Dressing									
Using the Toilet									
Transferring									
							Spoon Fed	Tube Fed	IV Fed
Feeding Self									

Continence	Needs No Help	Occasional Incontinence	Frequent Incontinence	External Device / Indwelling / Ostomy (Self Care)	External Device (Not Self Care)	Indwelling Catheter (Not Self Care)	Ostomy (Not Self Care)
Bowel							
Bladder							

Ambulation	Needs No Help	Mechanical Help Only	Human Help		Mechanical Help and Human Help		Performed by Others
			Supervision	Physical Assistance	Supervision	Physical Assistance	
Walking							
Wheeling							
Stair-climbing							
	Able to Move About at Home			Not Able to Move About			
If Homebound							

Activity	Needs Help?	
	Yes	No
Meal Preparation		
Housekeeping		
Laundry		
Managing Money		
Transportation		

Activity	Needs Help?	
	Yes	No
Shopping		
Using Phone		
Yard Care		
Pet Care		
Grooming		

Monthly Expense: Item	Amount
Mortgage/Rent	
Property Tax	
Home Maintenance and Upkeep	
Homeowners Insurance	
Utilities (gas, electric, water & sewer, security)	
Residential Facility	
Private Health Care Services	
Telephone	
Cable Television	
Vehicle Operation (Gas and Maintenance)	
Vehicle Insurance	
Clothing	
Groceries and Other Household	
Hair Cuts, Personal Grooming	
Laundry and Cleaning	
Checking Account Charges/Bank Fees	
Newspapers and Magazines	
Recreation, Vacation, Entertainment	
Health Insurance (such as Medicare supplement)	
Unreimbursed Medical Expenses (such as for drugs)	
Life Insurance	
Charitable Contributions	
Other:	
Other:	
Other:	
Other:	
Total Monthly Expenses:	$0

Anticipated maintenance needed for your home (e.g., roof, siding, windows, painting, repairs, driveway, etc.):

Item	Cost
Total:	$0

Monthly Care Costs (In-Home Care, Assisted Living, or Nursing Home Care), if applicable:

Monthly Care Cost: _____
Monthly Incontinent Cost: _____
Monthly Prescription Cost: _____
Monthly Other Cost: _____

Total Monthly Cost: $0

Money You Owe

Creditor's Name	Amount Owed
Total:	$0

Public Benefits and Community Services

Other than Social Security and Medicare, do you receive any other form of assistance, either from the government, charitable organizations, churches, or volunteer organizations? (Examples include: Veterans benefits, Section 8 housing or other subsidized housing, Medicaid, Tricare for Life, Meals on Wheels, subsidized transportation services, adult day care, support group services, or property tax relief.) ☐ Yes ☐ No If yes, please list them below:

Provider	Form of Assistance

Gifts and Uncompensated Transfers

Have you made any gifts of more than $100 to any individual, charity, or trust within the last 60 months? ☐ Yes ☐ No
If yes, please furnish the indicated information for each gift or transfer (use additional pages if necessary):

To Whom:	To Whom:
Date of Gift:	Date of Gift:
Item:	Item:
Value:	Value:
To Whom:	To Whom:
Date of Gift:	Date of Gift:
Item:	Item:
Value:	Value:

Have you, in the past 5 years, paid money for someone else's benefit (for example, paying for a child's wedding, paying for a grandchild's education, etc.)? ☐ Yes ☐ No
Have you made any loans that are still outstanding?, i.e., does anybody owe you money? ☐ Yes ☐ No
Have you lost any money gambling in the past 5 years? ☐ Yes ☐ No
If yes to any of the above, please explain below or on additional pages:

_____

_____

Have you ever filed a Federal Gift Tax Return? ☐ Yes ☐ No