SPOUSAL FINANCIAL DATA FORM

RESPONSIBLE PARTY:
Name ______
Address ______
City ______ Zip ______
Phone(H) ______
(W) ______

REFERRED TO
Senior Planning Services By:
______
______
______

*Relationship to applicant:*________________________ E*mail Address*:____

In order for Senior Planning Services to conduct a review and analysis of your financial planning profile, and to induce Senior Planning Services to provide an Estate Preservation Analysis, you agree to provide the information below.

ALL INFORMATION CONTAINED IN THIS APPLICATION WILL BE TREATED CONFIDENTIALLY. However, you agree that Senior Planning Services may present this document to such parties, as it deems appropriate if called upon to establish that the transactions suggested to you, if effected, were reasonable, lawful and appropriate. You understand that a false statement by you will constitute a violation of your representations and warranties in this application. You also understand that Senior Planning Services will rely entirely upon the information provided in this application in making its suggestions to you for Estate Preservation Analysis purposes and will be under no obligation to conduct any independent investigation or verification of the facts disclosed herein.

You, the undersigned applicant, hereby supply the following information and make the following representations and warranties to Senior Planning Services:

1. Full Name of Applicant: (Person in or going into Nursing Home)
Male: ______ Female: ______

____

Veteran of WWII, Korea, Vietnam, Persian/Gulf ☐ Yes ☐No

2. Full Name of Spouse:

____

Veteran of WWII, Korea, Vietnam, Persian/Gulf ☐ Yes ☐No

3. **Residence Address and Telephone Number**
____
____

Phone: (   ) ____________________

4. **Date of Birth: Applicant** _____/_____/_____
Spouse _____/_____/_____

5. **Marital Status: Married ___ Single ____ Separated ___**
Divorced___ Widowed ___

6. **The applicant supports the following dependents, other than your Spouse:**

Name	**Age**	**Relationship**
________________	____________	________________
________________	____________	________________

7. **Name of Power of Attorney:**
____
Phone (Work)_______________________________________
Phone (Home)_______________________________________

8. **Is there a Guardianship? Yes _____ No ______**
____
____

Substantial Gifts, Loans or Transfers of Money or Property:

9. Have you made any substantial gifts, loans or have you transferred any money or property to anyone in the last 60 months?
YES____ or NO _____

If your answer is **YES***, show the month and year of the gift, loan or transfer and the amount or value of each.*

(Date)	(Circumstances and Value)
_____/_____/____	________________________________
_____/_____/____	________________________________
_____/_____/____	________________________________

10. Are you a beneficiary of any trust? YES____ or NO _____
If yes, please describe the terms of the trust, including any rights that you have to amend or terminate, describe the trust property and its value and identify who contributed the property to the trust.
____
____
____

11. Has the applicant or the spouse had a Medicaid Assessment done by the Dept. of Health and Human Services Commission or have they applied for Medicaid benefits previously?
YES____ or NO _____

12. Is the applicant(s) currently in a nursing home?_________
Date of entry into Nursing Facility? ____________________
If ***No***, are you contemplating nursing Facility placement within the next few months? ________________________________

13 Did the applicant transition directly from a hospital or any other Medical Care Facility into the Nursing Facility?
YES____ or NO _____ If answered *Yes*, what was the date of entry into the hospital or Medical Care Facility ?____

14. What is the Medical diagnosis of the applicant?
____

15. Is the applicant taking Medication for the diagnosis?
YES____ or NO _____

16. Is the applicant capable of medicating himself/herself?
YES____ or NO_____

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17. Assets: Please state the estimated fair market value, as of the date of this application, of the combined interest of you and your spouse in all of your assets, without deduction for secured liabilities or exemptions as follows:

	Total Amount on 1st Day of Month When Entered Nursing Facility or Hospital *If not in nursing home leave this column blank*	**Current Asset Amounts**
	Month ________ Year _______	Month _______ Year________________
1) Residence *(Tax District Appraised Market Value)*	$____________________	$________________________________
2) Other Real Estate *(Tax District Appraised Market Value)*	$____________________	$________________________________
3) Real Estate Notes Held	$____________________ *Remaining Balance(s)*	$____________________________________ *Remaining Balance(s)*
4) Automobile(s) *(Year, Make, Model & Value of Each)*	(1) $____________________ (2) $____________________ (3) $____________________	(1) $________________________________ (2) $________________________________ (3) $________________________________
5) Recreational Vehicles or Travel Trailers *(Year, Make, Model & Value)*	$____________________	$________________________________
6) IRA, Keogh, 401K *(Circle the Appropriate One)*	$____________ Applicant $_______________ Spouse	$________________ Applicant $________________ Spouse
7) Checking Account(s) *(Total of All)*	$____________________	$________________________________
8) Savings Account(s) *(Total of All)*	$____________________	$________________________________
9) Money Market(s) *(Total of All)*	$____________________	$________________________________
10) Certificate of Deposits(s) *(Total of All)*	$____________________	$________________________________
11) Mutual Fund *(Total of All)*	$____________________	$________________________________
12) Stocks *(Total of All)*	$____________________	$________________________________
13) Bonds *(Total of All)*	$____________________	$________________________________
14) Cash Value/Life Insurance *(Show Face Amount of Each Policy and Cash Value)*	$____________ Applicant (Face Amount) $___________ Spouse (Face Amount)	$________________ Applicant (Face Amount) $________________ Spouse (Face Amount)
$____________ $____________	$______________________ Applicant (Cash Value) Spouse (Cash Value)	$________________ Applicant (Cash Value) Spouse (Cash Value)
(15) Annuity Contracts *(Show Current Cash Value)*	$____________ Applicant $___________ Spouse	$________________ Applicant $________________ Spouse
Total of Assets (1-15)	**$____________________**	**$________________**

SPOUSAL FINANCIAL DATA FORM

Assets *(Continued):* Please state the estimated fair market value, as of the date of this application, of the combined interest of you and your spouse in all of your assets, without deduction for secured liabilities or exemptions as follows:

	Total Amount on 1st Day of Month When Entered Nursing Facility or Hospital *If not in nursing home leave this column blank*	**Current Asset Amounts**
16) Burial Plots	$__________	$__________ $__________
17) Prepaid Burial Policies	$_____ Applicant $_____ Spouse	$_____ Applicant $_____ Spouse
18) Mineral Rights	$__________ Tax District Market Value if Producing	$__________ Tax District Market Value if Producing
19) Livestock	$__________ Number of Head and Value	$__________ Number of Head and Value
20) Farm Equipment	$__________ Value of All	$__________ Value of All
21) Life Estate (If yes, explain below)	☐ Yes ☐ No	☐ Yes ☐ No
22) Other current assets (list):	$__________	$__________
________________	$__________	$__________
________________	$__________	$__________
Total of Assets (1-15)	**$**__________	**$**__________
Total of Assets (16-22)	+ **$**__________	$__________
TOTAL ASSETS:	= $__________	$__________
23) Number of Married Children	__________	
Number of Unmarried Children	__________	

Notes:

____

____

____

____

____

____

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18. Income: Give the estimated average current ***monthly*** income of you and your spouse, consisting of:

	Applicant	Spouse
1) Social Security	Gross $_____Net $_____	Gross $_____Net $_____
2) Pension (*Source*________________)	Gross $_____Net $_____	Gross $_____Net $_____
3) IRA *Check One:* ☐ *Monthly* ☐ *Yearly*	$________________	$________________
4) Income Annuity (Pays out principal & Interest)	$________________	$________________
5) Interest Income (CDs, Savings Accounts, Fixed Annuities, Etc.)	$________________	$________________
6) Dividends (Stocks, Bonds, Mutual Funds, Etc.)	$________________	$________________
7) Rental Income *(Rent Houses or Buildings)*	$________________	$________________
8) Oil or Gas Income *Check One:* ☐ *Monthly* ☐ *Quarterly* ☐ *Yearly*	$________________	$________________
9) Farm Income		
a) Rental Income *(Yearly)*	$________________	$______
b) Share Crop *(Yearly)*	$________________	$______
c) Government Subsidy *(Yearly)*	$________________	$_____
d) Sale of Livestock *(Yearly)*	$________________	$_____
e) Crops *(Yearly)*	$________________	$_____
10) Hunting Lease Income *(Yearly)*	$________________	$________________
11) Other Income (Describe)	$________________	$________________
____________________________	$________________	$________________
____________________________	$________________	$________________
TOTAL INCOME:	**$________________**	**$________________**

Cost of Care $____________________
(Daily Room Rate X 31 Days)

Drug Cost $____________________
(Monthly Average)

Total Cost of Care $______________________

If the applicant is in the nursing facility, is he/she currently on Medicare? ☐ **Yes** ☐ **No** **If Yes, how many days remaining?________**
Monthly Cost of Medicare Supplement for Applicant $____
Do you have a Long Term Care Policy? ☐ **Yes** ☐ **No** **If Yes, what are the daily benefits?**

Outstanding Debts

1. SPS Fee ____
2. Balance to Nursing Home
   a. Current Month ____________________________________
   b. Succeeding Month _________________________________
3. Other
   a. ____
   b. ____
   c. ____
   d. ____
   e. ____
   f. ____

The information submitted herein was given by me and to the best of my knowledge is accurate. If it is not accurate or is incorrect then I take full responsibility for the information submitted.

Authorized ____________________________________ *Date* _______________*Initials*________________