LONG-TERM CARE PLANNING INTAKE SHEET

CLIENT INFORMATION:

Client's First Name: _____ Middle:_____ Last: _____

Please State Client's: Age or "Deceased":_____ DOB: _____ Social Security Number: _____

Phone #: Home ( ) _____ Cell ( )_____Work ( )_____

Address: _____ Email:_____

City: _____ State: _____ Zip Code: _____

MILITARY INFORMATION: Honorably discharged from the military? ☐ Yes ☐ No Discharge papers? ☐ Yes ☐ No

Dates of Service? From: _____To: _____

Branch of Service? ☐ Army ☐ Navy ☐ Air Force ☐ Marines Coast Guard ☐ Other:_____

SPOUSE INFORMATION:

Spouse's First Name: _____ Middle: _____Last:_____

Please State Spouse's: Age:_____ DOB: _____ Social Security Number: _____

☐ Check here if spouse's contact information is the same as Client above

Phone #: Home ( ) _____ Cell ( )_____Work ( )_____

Address: _____ Email:_____

City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION, if other than Client or Spouse:

Name: _____Relationship to Client or Spouse:_____

Phone #: Home ( ) _____ Cell ( )_____Work ( )_____

Address: _____ Email:_____

City: _____ State: _____ Zip Code: _____

CLAIM STATUS: ☐ **Medicaid** ☐ married ☐ single ☐ **VA Aid and Attendance**

☐ Veteran Couple (2 Veterans) ☐ Married Veteran ☐ Single Veteran ☐ Surviving Spouse

If a Surviving Spouse Claim, was the spouse married to the veteran at the time of death? ☐ Yes ☐ No

If yes, has she remarried since the death of the Veteran? ☐ Yes ☐ No Still married? Yes No

TYPE OF CARE BEING RECEIVED: ☐ Assisted Living ☐ Skilled Nursing ☐ In-Home Care by Licensed Provider ☐ In-Home Care by Family Member ☐ Memory Care

Is care being provided for the spouse of the veteran only? ☐ Yes ☐ No

COMMENTS: (names of children, unique circumstances, etc.)

_____

_____

_____

Please check the appropriate box for all Medical Conditions and Care Services Provided for which the Claimant receives care by either a Care Provider, if receiving In Home Care, or a community.

Medical Condition		ADL's Provided	
Heart Disease	☐	**Assistance w/Bathing and Personal Hygiene**	☐
Hypertension	☐	**Assistance w/Grooming**	☐
Stroke	☐	**Assistance w/Dressing**	☐
Cancer	☐	**Assistance w/Administering Medications**	☐
Mental Disorder	☐	**Assistance w/Ambulation, Escorts and Transfers**	☐
Kidney Disorder	☐	**Incontinence Care (Depends and or Pads)**	☐
Disorder of Spine, Joints, Bones	☐	**Assistance w/Toileting (Day and/or Evening)**	☐
Diabetes	☐	**Monitored Environment (Day and/or Night)**	
Stomach Disorder	☐	**Assistance w/Special Diets (Low Sodium or Glucose)**	☐
Alzheimers or Dementia	☐	**Transportation to Medical Appointments**	☐
Incontinent	☐	**Regular Liaison with Physician(s) or Pharmacy**	☐
Use of Scooter, wheelchair, Walker and/or Cane	☐	**Assistance w/ Oxygen or Diabetic Supplies**	☐
High Fall Risk	☐	**Physician Ordered Vital Signs or Variable Insulin Calculations**	☐
Other:	☐	**Specialized Care Environment (Secure Dementia Facilities)**	☐
Other:	☐	**Ancillaries Provided**	
Other:	☐	**Environmental Cleanliness (Housekeeping and Chores)**	☐
Other:	☐	**Assistance w/Meal Preparation**	☐
Other:	☐	**Personal Errands (Shopping)**	☐
Other:	☐	**Laundry** **Linens** **Personal**	☐ ☐

<u>OTHER MEDICAL NOTES (*for official use only*)</u>:

_____

_____

_____

_____

<u>PHYSICIAN INFORMATION *(for official use only)*</u>*:*

Name:_____ How many years under this physician's care?_____

Address: _____

City: _____State: _____Zip: _____

Phone: _____ Fax: _____

FACILITY OR CARE PROVIDER INFORMATION:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Facility Contact Name: _____Email: _____

Phone: _____Fax: _____Alternate: _____

MONTHLY EXPENSES:

Expense	Client	Spouse
Cost of Care (Home Healthcare, ALF, Memory or Skilled Care)		
Medicare B		
Supplemental Health Care Policy Premium		
Unreimbursed Prescriptions	**N/A**	
Unreimbursed Oxygen Supplies		
Private Duty Care or Nursing		
Incontinence Supplies		
Diabetic Equipment and Supplies		
Other Medical Expense Explain: _____		
TOTAL		

INCOME:

Asset	Client	Spouse
Gross Social Security		
Civil Service Pension		
Military Retirement or SBA		
VA Compensation pay - disability		
Retirement Source:		
Retirement Source:		
IRA/Money Market/Annuity Payment		
IRA/Money Market/Annuity Payment		
Long Term Care Insurance		
Interest Income Sources:		
Rental Income		
Other		
Other		
TOTAL		

ASSETS:

Asset	Joint	Client	Spouse
Checking	☐		
Savings/CDs (Total)	☐		
CD's (Total)	☐		
IRA/401K [Surrender Penalty: (_____)			
Stocks/Bonds (Total)	☐		
Rental Property(ies) (Net Value)	☐		
Home Value: Mortgage Balance: $_____	☐		
Life Insurance Cash Value (Face: S_____)	☐		
Annuities (Total)	☐		
Other Asset Source:	☐		
Other Asset Source:	☐		
Other Asset Source:			
TOTAL			

Has the client or their spouse prepaid their funeral expenses? Client: _____ Spouse: _____

Has the client or their spouse given any assets away within the past five years? _____ If yes, how much? _____

To Whom? _____

Legal Papers

_____Will or Trust (Trust type: □ Revocable □ Irrevocable). Last update: _____

_____POA Client. Name of POA: _____

_____POA Spouse. Name of POA: _____

_____Medical Directives Client. Type of documents: _____ Living Will _____Do not resuscitate

_____Medical Directives Spouse. Type of documents: _____Living Will _____Do not resuscitate

ADDITIONAL COMMENTS:

_____
_____
_____
_____
_____
_____

AGENT/ADVOCATE INFORMATION:

Name: _____

Address: _____City:_____State:_____Zip: _____

Phone: _____ Fax: _____ E-mail: _____

WARTIME ELIGIBILITY DATES OF SERVICE:

War	Eligible Dates
World War I	April 6, 1917 to November 11, 1918
World War II	December 7, 1941 to December 31, 1946
Korea	June 27, 1950 to January 31, 1955
Vietnam- All Other	August 5, 1964 to May 7, 1975
Vietnam In- Country	February 28, 1961-May 7, 1975
Lebanon	August 25, 1982 to To Be Determined
Grenada	October 25, 1983 to December 15, 1983
Panama	December 20, 1989 to January 31, 1990
Persian Gulf	August 2, 1990 to To Be Determined