RESPONSIBLE PARTY:

Name _____

Address _____

City *Zip* _____

Phone$_{(H)}$ _____

(W) _____

REFERRED TO
***Senior Planning Services By*:**

_____

_____

_____

Senior Planning Services
Estate Preservation Analysis
3800 E. 42 nd Street, Suite 512
Odessa, TX 79762
(432)550-6800 * (866)304-6800
FAX (432)550-9600

*Relationship to applicant:*_____ *Email 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 affected, 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 _____/_____/_____

Place of Birth:_____

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**

_____

_____

Applicant Information Approval (initials)_____

9. Substantial Gifts, Loans or Transfers of Money or Property:

(a) Have you made any substantial gifts, loans or have you transferred any money or property to anyone in the last 60 months? Yes ____ 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 ___ 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 Human & Human Services Commission or have they applied for Medicaid benefits previously? YES _____ NO_____

12. Is the applicant(s) currently in a nursing home?_____

Date of entry into Nursing Facility? _____

Name of Nursing Home_____

Address_____

City_____ ZIP_____

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_____ 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_____

FINANCIAL DATA FORM

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

	IF APPLICANT IS MARRIED **Total Amount on 1st Day of Month When Entered Nursing Facility OR Hospital**	IF APPLICANT IS SINGLE **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 (Cash Value) $_____ Spouse (Cash Value)	$_____ Applicant (Face Amount) $_____ Spouse (Face Amount) $_____ Applicant (Cash Value) $_____ Spouse (Cash Value)
(15) Annuity Contracts *(Show Current Cash Value)*	$_____ Applicant $_____ Spouse	$_____ Applicant $_____ Spouse
Total of Assets (1-15)	$_____	$_____

Applicant Information Approval (initials)_____

FINANCIAL DATA FORM

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

	IF APPLICANT IS MARRIED		IF APPLICANT IS SINGLE
	Total Asset Amounts on 1st Day of Month When Entered Nursing Facility OR Hospital		**Current Asset Amounts**
	Applicant	Spouse	Applicant
16) Burial Plots	$_____	$_____	$_____
(a) # of spaces/plots	_____	_____	_____
(b) Name of Cemetery	_____	_____	_____
17) Prepaid Burial Policies	$_____	$_____	$_____
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	_____		
24) Safety Deposit Box?	_____		_____
(a) Contents?	_____		_____

Notes:

_____

_____

_____

_____

Applicant Information Approval (initials)_____

FINANCIAL DATA FORM

19. Income: Give the estimated average current ***monthly*** income of both married spouses or single applicant, 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 **$**_____

Are you currently on Medicare? ☐ Yes ☐ No If Yes, how many days remaining? _____
Monthly Cost of Medicare Supplement for Applicant $_____ Monthly Cost of Medicare Part D? _____
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. _____ d. _____
   b. _____ e. _____
   c. _____ 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**_____