

**Long-Term Care Financial and Personal Resources Review**  
Prepared for:

Prepared by:

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### Personal and Family Information

|          | Name  | Date of Birth | Cell Phone Number | E-Mail Address |
|----------|-------|---------------|-------------------|----------------|
| Client   | _____ | ___/___/___   | _____             | _____          |
| Spouse   | _____ | ___/___/___   | _____             | _____          |
| Children | _____ | ___/___/___   |                   |                |
|          | _____ | ___/___/___   |                   |                |
|          | _____ | ___/___/___   |                   |                |
|          | _____ | ___/___/___   |                   |                |

### Residence Information

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Telephone No: \_\_\_\_\_

Own?      Mortgage Payment: \_\_\_\_\_      Mortgage Balance: \_\_\_\_\_

Rent?      Monthly Rent: \_\_\_\_\_

### Employment Information

|                | Client | Spouse |
|----------------|--------|--------|
| Occupation:    | _____  | _____  |
| Employer:      | _____  | _____  |
| Annual Income: | _____  | _____  |
| Other Income:  | _____  | _____  |

### Long-Term Care Planning Concerns

What are your biggest concerns about planning for your health care as you age?

Exhausting my assets and/or income to pay for needed health care.

Becoming a burden to my family and/or friends to help care for me.

Maintaining control over my health care decisions.

Keeping my dignity in the event I need extended care.

Other:

| Financial Information             |  |                         |  |
|-----------------------------------|--|-------------------------|--|
| Assets                            |  | Liabilities             |  |
| Savings _____                     |  | Installment Loans _____ |  |
| Investments _____                 |  | Mortgage(s) _____       |  |
| IRA(s) _____                      |  | Charge Accounts _____   |  |
| Real Estate _____                 |  | Credit Cards _____      |  |
| Business Interests _____          |  | Personal Notes _____    |  |
| Personal Property _____           |  | Business Debt _____     |  |
| Other _____                       |  | Other _____             |  |
| Total Assets _____                |  | Total Liabilities _____ |  |
| Monthly Systematic Savings: _____ |  |                         |  |

| Insurance Information |         |               |             |             |                |             |
|-----------------------|---------|---------------|-------------|-------------|----------------|-------------|
| Life Insurance        |         |               |             |             |                |             |
| Insured               | Company | Policy Number | Policy Date | Face Amount | Annual Premium | Beneficiary |
|                       |         |               |             |             |                |             |
|                       |         |               |             |             |                |             |
|                       |         |               |             |             |                |             |
|                       |         |               |             |             |                |             |
|                       |         |               |             |             |                |             |

**Other Insurance**

Monthly Disability Benefit: Client \_\_\_\_\_ Spouse \_\_\_\_\_

Health Insurance: Client Yes No Spouse Yes No

Long-Term Care Insurance: Client Yes No Spouse Yes No

P&C Expiration Dates: Auto: \_\_\_\_/\_\_\_\_/\_\_\_\_ Homeowners: \_\_\_\_/\_\_\_\_/\_\_\_\_ Other: \_\_\_\_/\_\_\_\_/\_\_\_\_

| Document Information                 |                                      |
|--------------------------------------|--------------------------------------|
| Client's Will: Date _____ Type _____ | Spouse's Will: Date _____ Type _____ |

| Professional Advisors    |                  |
|--------------------------|------------------|
| Attorney: _____          | Phone No.: _____ |
| Accountant: _____        | Phone No.: _____ |
| Insurance Agent: _____   | Phone No.: _____ |
| Financial Planner: _____ | Phone No.: _____ |

## Long-Term Care Resources

### 1. Health Coverage

Do you believe your current health coverage adequately covers:

|                            |     |    |
|----------------------------|-----|----|
| A. Hospitalization costs?  | Yes | No |
| B. Nursing home costs?     | Yes | No |
| C. Home health care costs? | Yes | No |
| D. Assisted living costs?  | Yes | No |

### 2. Health Care Preferences

If you suffered a long-term disability as a result of a stroke, where would you prefer to receive care?

|                              |     |    |
|------------------------------|-----|----|
| A. Nursing home?             | Yes | No |
| B. Assisted living facility? | Yes | No |
| C. Own home?                 | Yes | No |

### 3. Financial Resources for Health Care

If you were faced with a nursing home bill of \$77,000\* right now, how would you pay for it?

|                   |     |    |
|-------------------|-----|----|
| A. From savings?  | Yes | No |
| B. Bank loan?     | Yes | No |
| C. Other sources? | Yes | No |

Describe:

\* The 2008 MetLife Market Survey of Nursing Home and Assisted Living Costs found that the private-room cost for a year in a nursing home ranges from \$48,180 in Louisiana to over \$131,000 in New York City, with a national average of \$77,380.

For how long could you personally afford to pay a \$77,000 nursing home bill from those resources?

|  |     |    |
|--|-----|----|
| A. 1 year?   | Yes | No |
| B. 2.5 years ( <i>the average nursing home stay</i> )? | Yes | No |
| C. 5 years or longer?                                  | Yes | No |

Will your children be in a financial position to help pay for this care?

|     |    |
|-----|----|
| Yes | No |
|-----|----|

Given a choice, how would you prefer to pay for this care?

|                        |     |    |
|------------------------|-----|----|
| A. Private resources?  | Yes | No |
| B. Insurance Benefits? | Yes | No |

If your answer is insurance, is there any reason why you haven't purchased it?

#### 4. Personal Resources for Health Care

If you became ill tomorrow, would your family:

- |   |     |    |
|---|-----|----|
| A. Be able to provide you with at-home medical care?                | Yes | No |
| B. Have the time to provide you with at-home care?                  |     |    |
| For a week?   | Yes | No |
| For a month?  | Yes | No |
| Nine months?  | Yes | No |
| A year or more?   | Yes | No |
| C. Be physically able to provide at-home care on a long-term basis? | Yes | No |
| D. Be able to quit work to provide care?                            | Yes | No |

#### 5. Goals for Financial Resources

- |  |     |    |
|--|-----|----|
| A. Would you like to leave an estate to your children?                       | Yes | No |
| B. Would you like to help pay for your grandchildren's education?            | Yes | No |
| C. Do you want to remain in control of decisions regarding your health care? | Yes | No |
| D. Would you want to die impoverished and in debt?                           | Yes | No |

## Important Information

This fact finder serves to help identify your financial needs and priorities and may be used in developing proposed solutions consistent with your needs and objectives. In completing this fact finder, you are entrusting our organization with certain personal and confidential financial data. We recognize that our relationship with you is based on trust and we hold ourselves to the highest standards in the safekeeping and use of your confidential information.

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