Let's F. E. H. L. Our Way Through A Long Term Care Event

Proactive planning for a long term care event

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The attached is a guideline only for your personal use. Please feel free to make additions if needed. This is not to be used for legal advice or financial planning guidance. For legal or financial assistance, please contact your legal or financial professional.

Organizational Calendar

Proactive Planning for a Long Term Care Event

4 Categories of Planning: **F**inancial, **E**nvironmental, **H**ealth and **L**egal

January	**February**	**March**
F. _____ **E.**	**F.** _____ **E.**	**F.** _____ **E.**
H. _____ **L.**	**H.** _____ **L.**	**H.** _____ **L.**
April	May	June
F. _____ **E.**	F. _____ E.	F. _____ E.
H. _____ **L.**	H. _____ L.	H. _____ L.
July	August	September
F. _____ **E.**	F. _____ E.	F. _____ E.
H. _____ **L.**	H. _____ L.	H. _____ L.
October	November	December
F. _____ **E.**	F. _____ E.	F. _____ E.
H. _____	H. _____	H. _____
L. _____	L. _____	L. _____

Steps:

Each month for 12 months pick 1 item from each of the 4 categories. Once complete, write the number of the item next to the corresponding category (F, E, H or L) in the appropriate month.

Financial

1. Make a list of user names or passwords for all accounts.
    a. Account: _____

       Username:_____ Password:_____

    b. Account: _____

       Username:_____ Password:_____

    c. Account: _____

       Username:_____ Password:_____

    d. Account: _____

       Username:_____ Password:_____

2. Make a list of debts - when are payments due? how do you pay?
    a. Debt: _____

       Payment due:_____Payment Method:_____

    b. Debt: _____

       Payment due:_____Payment Method:_____

    c. Debt: _____

       Payment due:_____Payment Method:_____

    d. Debt: _____

       Payment due:_____Payment Method:_____

3. Make a list of property and casualty insurance – when are payments due? how do you pay?

    a. Property and Casualty Insurance: _____

    Payment due:_____ Payment Method:_____

4. Make a list of expenses – when are payments due? how do you pay?

    a. Expenses: _____

    Payment due:_____ Payment Method:_____

    b. Expenses: _____

    Payment due:_____ Payment Method:_____

    c. Expenses: _____

    Payment due:_____ Payment Method:_____

    d. Expenses: _____

    Payment due:_____ Payment Method:_____

5. Create a system to collect income tax information. Include the contact information for your CPA.

    a. Located in the following:_____

    b. CPA: _____

    c. Phone:_____

6. Create a filing system for asset titles such as vehicles and real estate deeds.

    a. Located in the following:_____

7. Determine if any "regular" bills should be set up for auto pay – and if so, set them up.

    □ Completed

    □ Not completed

8. Make a list of your credit cards – include what you use them for (if specific use) and when payments are made and if there are any auto drafts.

    a. Credit card:_____
    Usage:_____ Payment due:_____
    Auto Draft:_____ Drafted:_____

b. Credit card:_____

Usage:_____Payment due:_____

Auto Draft:_____Drafted:_____

c. Credit card:_____

Usage:_____Payment due:_____

Auto Draft:_____Drafted:_____

9. Close any credit cards not currently in use.

□ Completed

□ Not completed

10. Determine if any of your bank accounts can be consolidated or closed – do so if applicable.

□ Completed

□ Not completed

11. Provide your CPA and financial advisors contact information for your Financial Power of Attorney.

□ Completed

□ Not completed

12. Complete the Client Asset Information Form and list ALL debts. (See Attached on page 21)

□ Completed

□ Not completed

Environment

1. De-clutter your home and give away or donate the items you don't use or want anymore.

    □ Completed

    □ Not completed

2. Discard old and outdated medications.

    □ Completed

    □ Not completed

3. Determine if you have an adequate security system and update if needed.

    □ Completed

    □ Not completed

4. Have an extra set of keys made for your house to give to a trusted friend or family member.

    □ Completed

    □ Not completed

    □ Name of person who has the key:_____

5. Determine if your bathroom is handicap accessible and if not make a list of what changes would be needed if required.

    a. Bathroom handicap accessible: □Yes □No

    b. What changes would need to be made: _____

    _____

    _____

6. Look at each room in your house as if you had to walk through it with a walker and determine if any changes need to be made to the layout.

    □ Completed

    □ Not completed

    □ What changes would need to be made: _____

    □ _____

    _____

7. Make a list of routine maintenance done at your home - include how often it is scheduled and how you pay.

    a. Company : _____Handle by:_____

    How often: _____ Payment: _____

    b. Company : _____Handle by:_____

    How often: _____ Payment: _____

    c. Company : _____Handle by:_____

    How often: _____ Payment: _____

8. Make a list of the names and contact information for neighbors - include what they would be relied on for.

    a. Neighbor :_____Phone: _____

    What they would do: _____

    b. Neighbor :_____Phone: _____

    What they would do: _____

    c. Neighbor :_____Phone: _____

    What they would do: _____

9. Is your bedroom on the second floor? If so, what would need to be done if you could no longer get to your bedroom on the second floor? Could you convert your dining room into a "bedroom."

    a. NOTES:_____

    _____

    _____

10. Do you have a shower or bathtub on the main floor? If not, what steps or plans would need to be done to ensure cleanliness?

    a. NOTES:_____

    _____

    _____

11. Get a wireless Emergency response system (i.e. life alert or some other system).

    □ Completed

    □ Not completed

12. Do you have family heirlooms? Write down the name of the person who this originally belonged to and put it with the item (i.e tea cup belonged to Jane Smith's Great Grandmother Betty White).

    □ Completed

    □ Not completed

Health

1. Make a list of doctors with their contact information – include how often you see each one.

    a. Doctor:_____ phone: _____

    Reason for visits:_____

    b. Doctor:_____ phone: _____

    Reason for visits:_____

    c. Doctor:_____ phone: _____

    Reason for visits:_____

    d. Doctor:_____ phone: _____

    Reason for visits:_____

    e. Doctor:_____ phone: _____

    Reason for visits:_____

2. Make a list of medicines – include how often you take them and who prescribes them.

    a. Medication: _____

    How often: _____ Prescribing Physician:_____

    b. Medication: _____

    How often: _____ Prescribing Physician:_____

    c. Medication: _____

    How often: _____ Prescribing Physician:_____

    d. Medication: _____

    How often: _____ Prescribing Physician:_____

e. Medication: _____

How often: _____ Prescribing Physician: _____

3. Visit health care facilities in your area and make notes on what you do and do not like.

a. Facility: _____ Phone: _____

NOTES: _____

_____

_____

b. Facility: _____ Phone: _____

NOTES: _____

_____

_____

c. Facility: _____ Phone: _____

NOTES: _____

_____

_____

d. Facility: _____ Phone: _____

NOTES: _____

_____

_____

4. Make a list of health insurance providers – include when premiums are due and how you pay.

a. Health insurance provider: _____

Premiums are due on: _____ Payment method: _____

b. Health insurance provider: _____

Premiums are due on: _____ Payment method: _____

c. Health insurance provider:_____

Premiums are due on: _____ Payment method:_____

5. Request a "Medical History" form from one of your doctors and fill it out for your records and don't forget to include medications. {see attached on page 18}

6. Meet with your preferred funeral home to plan your funeral service - include the information needed for your death certificate.

   □ Completed

   □ Not completed

7. If you are a Veteran – record your DD 214 in the Superior Court of your county of residence.

   □ Completed

   □ Not completed

8. Add the contact information for your local pharmacy to your list of medications – include the name of the pharmacist.

   a. Pharmacy : _____ Phone: _____

      Pharmacist: _____

9. Tell your Health Care Agent where to find the lists you've made.

   □ Completed

   □ Not completed

10. Provide your Advance Directive For Health Care to your doctors – include the contact information for your Health Care Agent(s).

    □ Completed

    □ Not completed

11. Provide information on your long term care policy. If you do not have a long term care policy, contact Stewardship Financial Advisors, LLC. to determine if a policy would be right for you.

    a. Company: _____ Policy Number: _____

       Phone number: _____ Payment due: _____

12. Make a copy of your medical insurance card and place it with your Advance Directive for Health Care.

    □ Completed

    □ Not completed

Legal

1. Tell your fiduciaries and family members – "Do not retitle assets in the event of death or incapacity until you speak with my attorney."

    □ Completed

    □ Not completed

2. Locate your Financial Power of Attorney. Is it up to date (every 1-2 years)? Is it effective now or only if you are incapacitated?

    a. Location: _____

    b. Last Updated: _____

    c. Effective now or on incapacitation: _____

3. Locate your Advance Directive for Health Care and send it to DocuClub, LLC with a membership enrollment form and annual fee (678-902-0829).

    a. Location: _____

    b. Last Updated: _____

4. Confirm if you have your originals or copies of your Advance Directive for Health Care and Financial Power of Attorney. Make sure you understand what they say.

    a. ADHC: □originals □copies

    b. FPOA: □originals □copies

5. If you have copies, tell your fiduciaries and family members where the originals are kept.

    □ Completed

    □ Not completed

6. Locate your long term care policy.

    □ Completed

    □ Not completed

    □ Location: _____

7. Set an appointment with your attorney if you have not reviewed your estate plan within the last 3 years.

    □ Completed

    □ Not completed

    □ Appointment set:_____

8. Discard outdated estate planning documents and only keep the most current copy.

    □ Completed

    □ Not completed

9. Contact your Health Care Agents and Financial Powers of Attorney and provide them with the name of your estate planning attorney and contact information.

    □ Completed

    □ Not completed

10. Research options for assistance with completing a long term care claims (example: Claim Jockey, LLC | 800-791-6324 | www.claimjockey.com)

    □ Completed

    □ Not completed

    □ NOTES: _____

    _____

    _____

11. Give a copy of your Financial Power of Attorney to your financial institutions

    □ Completed

    □ Not completed

12. Confirm the beneficiaries on your IRA's and life insurance.

    □ Completed

    □ Not completed

Personal Medical History Form

Name: _____ **Birthdate:** _____

Physician: _____ **Telephone Numbers:** _____

Dentist: _____ _____

Eye Doctor: _____ _____

Other: _____ _____

Your current medical condition: _____

_____

List prescription and non-prescription medications you are taking: _____

_____

_____

Drug sensitivity and allergies (describe): _____

_____

Name of Health Insurance Carrier: _____

Group Number: _____ **Policy Number:** _____

Have you ever been told you had one of the following?

Lung disorder ☐ yes ☐ no
High blood pressure ☐ yes ☐ no
Heart trouble ☐ yes ☐ no
Nervous disorder ☐ yes ☐ no
Disease or disorder of the digestive tract ☐ yes ☐ no
Any form of cancer ☐ yes ☐ no
Disease of the kidney ☐ yes ☐ no
Diabetes ☐ yes ☐ no
Arthritis ☐ yes ☐ no
Hepatitis ☐ yes ☐ no
Malaria ☐ yes ☐ no

Disease or disorder of the blood? (describe) _____
Any physical defect or deformity? (describe) _____
Any vision or hearing disorders? (describe)_____
Any life-threatening conditions? (describe)_____
Any contagious disorders? (describe) _____

Have you been treated by a physician or been disabled or hospitalized during the last year? (describe):

_____

_____

_____

Have you had or been advised to have a surgical operation within the last five years? (describe):

_____

_____

_____

Date of last physical: _____

Date of last tetanus shot: _____

Family history – List important medical problems of your parents:

Mother: _____

_____

Father: _____

_____

Any other special Medical information:

_____

_____

_____

Personal and Confidential

CLIENT ASSET INFORMATION

DATE: _____

CLIENT 1: _____ **CLIENT 2 (I.E. SPOUSE):** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CLIENT 1 SOCIAL SECURITY NUMBER _____ **CLIENT 1 BIRTH DATE** _____

CLIENT 2 SOCIAL SECURITY NUMBER _____ **CLIENT 2 BIRTH DATE** _____

HOME PHONE: _____ **CLIENT 1 WORK PHONE:** _____

OTHER PHONE: _____ **CLIENT 2 WORK PHONE:** _____

ESTATE VALUE SUMMARY

ASSET DESCRIPTION	CLIENT 1*	JOINT* (JT OR RLT)	CLIENT 2*
CASH ACCOUNTS			
Checking Accounts			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
4.	$	$ ( )	$
Savings Accounts			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
4.	$	$ ( )	$
Money Market Accounts			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
4.	$	$ ( )	$
Certificates of Deposit			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$

Client 1 alone (C1), Client 2 alone (C2), Joint Ownership (JT), or in the name of the Revocable Living Trust (RLT)

ASSET DESCRIPTION	CLIENT 1*	JOINT* (JT OR RLT)	CLIENT 2*
INVESTMENT SECURITIES			
Brokerage Accounts			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
Individual Stock Certificates			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
Dividend Reinvestment Accounts			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
U.S. Savings Bonds			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
U.S. Treasury Direct			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
PARTNERSHIP / BUSINESS INTERESTS			
NAME:	$	$ ( )	$
NAME:	$	$ ( )	$
REAL PROPERTY INTERESTS			
Georgia Property			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
Mortgage(s) on Georgia Property	< >	< >	< >

Client 1 alone (C1), Client 2 alone (C2), Joint Ownership (JT), or in the name of the Revocable Living Trust (RLT)

ASSET DESCRIPTION	CLIENT 1*	JOINT* (JT OR RLT)	CLIENT 2*
REAL PROPERTY INTERESTS – CONT'D			
Out of State Property			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
Mortgage(s) on Out of State Property	< >	< >	< >
NOTE RECEIVABLES			
1.	$	$ ( )	$
2.	$	$ ( )	$
3.	$	$ ( )	$
LIFE INSURANCE (LIST BELOW)	$	$ ( )	$
RETIREMENT PLANS			
IRAs (list on attached)	$	$ ( )	$
Annuities (list on attached)	$	$ ( )	$
Qualified (Pension) Plans (list on attached)	$	$ ( )	$
TOTAL	$	$ ( )	$

Client 1 alone (C1), Client 2 alone (C2), Joint Ownership (JT), or in the name of the Revocable Living Trust (RLT)

LIFE INSURANCE

For all policies, please list the information requested.

Company: _____ Policy Number: _____
Address: _____ City, State, Zip: _____ Insured:
Type*: _____ Face Amount: $_____ Owner: _____ Cash
Value: $_____ Primary Beneficiary: _____ Secondary Beneficiary: _
** Term (T), Whole Life (WL), Universal Life (UL), Split Dollar (SD), Group Life (GL)*

Company: _____ Policy Number: _____ Address:
City, State, Zip: _____ Insured: _____ Type*:
Face Amount: $_____ Owner: _____ Cash Value:
$_____ Primary Beneficiary: _____ Secondary Beneficiary: _____
** Term (T), Whole Life (WL), Universal Life (UL), Split Dollar (SD), Group Life (GL)*

Company: _____ Policy Number: _____ Address:
City, State, Zip: _____ Insured: _____ Type*:
Face Amount: $_____ Owner: _____ Cash Value:
$_____ Primary Beneficiary: _____ Secondary Beneficiary: _____
** Term (T), Whole Life (WL), Universal Life (UL), Split Dollar (SD), Group Life (GL)*

RETIREMENT PLANS

For all Retirement Plans, please list the information requested.

INVESTMENT RETIREMENT ACCOUNTS (IRAS):

Company: _____ Account Number: _____
Address: _____ City, State, Zip: _____ Owner:
Value: $_____ Primary Beneficiary: _____ Secondary Beneficiary:

Company: _____ Account Number: _____ Address:
City, State, Zip: _____ Owner: _____ Value:
$_____ Primary Beneficiary: _____ Secondary Beneficiary: ___

Company: _____ Account Number: _____ Address:
City, State, Zip: _____ Owner: _____ Value:
$_____ Primary Beneficiary: _____ Secondary Beneficiary: ___

ANNUITIES:

Company: _____ Contract Number: _____
Address: _____ City, State, Zip: _____ Owner/Annuitant:
Type*: _____ Annuity Amount: $_____ Lifetime Beneficiary: _____ Death
Beneficiary: _____
** Immediate Annuity (I), Deferred Annuity (D)*

Company: _____ Contract Number: _____ Address:
City, State, Zip: _____ Owner/Annuitant: _____ Type*:
Annuity Amount: $_____ Lifetime Beneficiary: _____ Death Beneficiary: _____
** Immediate Annuity (I), Deferred Annuity (D)*

Company: _____ Contract Number: _____ Address:
City, State, Zip: _____ Owner/Annuitant: _____ Type*:
Annuity Amount: $_____ Lifetime Beneficiary: _____ Death Beneficiary: _____
** Immediate Annuity (I), Deferred Annuity (D)*

QUALIFIED PLANS (PENSION PLANS):

COMPANY NAME AND ADDRESS	TYPE+	OWNER(S)*	DEATH BENEFICIARY	% VESTED	VALUE
_____	_____	_____	_____	_____%	$_____
_____					
_____					
_____	_____	_____	_____	_____%	$_____
_____					
_____					
_____	_____	_____	_____	_____%	$_____

****Client 1 alone (C1), Client 2 alone (C2), Joint Ownership (JT), or in the name of the Revocable Living Trust (RLT)+Pension (P), Profit Sharing (PS), Keogh (K), Other (O)***

NOTES