LONG-TERM CARE INSURANCE INTAKE FORM

A. Client Data

Married Single

Client Name: ______________________ Spouse/Partner: ______________________

Sex: ☐ Male ☐ Female Sex: ☐ Male ☐ Female

Street Address: ____

City: ______________________ State/Zip: __________ / __________

Client's Birth Date: ______________________ Spouse's Birth Date: ______________________

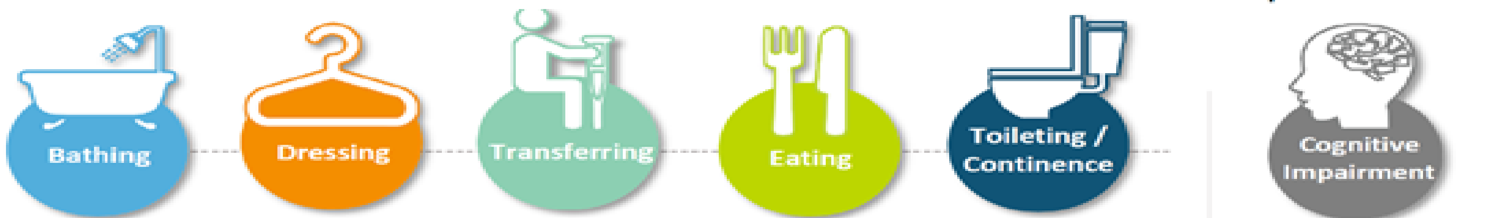
Client's Height: ______________________ Spouse's Height: ______________________

Client's Weight: ______________________ Spouse's Weight: ______________________

B. Health Data

	Client	Spouse
Do you use a wheelchair, walker, quad cane, hospital bed or been prescribed a handicap sticker?	Y ☐ N ☐	Y ☐ N ☐
Are you cognitively impaired, or do you need help with your ADL's?	Y ☐ N ☐	Y ☐ N ☐

Activities of Daily Living



	Client		Spouse	
Have you had any LTCI policy denied or rated up?	Y ☐	N ☐	Y ☐	N ☐
Are you Receiving disability benefits?	Y ☐	N ☐	Y ☐	N ☐
Have you used tobacco products in the last 5 years?	Y ☐	N ☐	Y ☐	N ☐
Have you been hospitalized in the last 5 years?	Y ☐	N ☐	Y ☐	N ☐
Do you use narcotic pain medication or medical marijuana?	Y ☐	N ☐	Y ☐	N ☐
Have you been treated for Diabetes?	Y ☐	N ☐	Y ☐	N ☐
Insulin	____________		____________	
AIc	____________		____________	
Has either of your parents been diagnosed with dementia?	Y ☐	N ☐	Y ☐	N ☐
At what age?	____________		____________	
Have you been treated for cancer in the last 5 years?	Y ☐	N ☐	Y ☐	N ☐
Have you been treated for Heart Disease in the last 5 years?	Y ☐	N ☐	Y ☐	N ☐
Have you been treated for Sleep Apnea in the last 5 years?	Y ☐	N ☐	Y ☐	N ☐
Have you been treated for Rheumatoid Arthritis or other auto immune disorder in the last 5 years?	Y ☐	N ☐	Y ☐	N ☐
Have you experienced vertigo?	Y ☐	N ☐	Y ☐	N ☐
Have you had any musculoskeletal disorders?	Y ☐	N ☐	Y ☐	N ☐

Please provide details to any questions listed above as "YES". Please include diagnosis, date, and treatment plan.

Client Additional Details

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Spouse Additional Details

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CLIENT MEDICATIONS

Prescription Name	Dosage	Frequency	Reason Prescribed

Have any medications changed within the last 6 months? ______________________________

When was your last complete physical with CBC testing? ______________________________

SPOUSE MEDICATIONS

Prescription Name	Dosage	Frequency	Reason Prescribed

Have any medications changed within the last 6 months? ______________________________

When was your last complete physical with CBC testing? ______________________________

C. Financial Information

	Husband's Monthly Income	Wife's Monthly Income
Employment Income	$ ____________________	$ ____________________
Social Security	$ ____________________	$ ____________________
Pension(s) Income (Gross)	$ ____________________	$ ____________________
Other Income*	$ ____________________	$ ____________________

*If other, please explain:

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The funding for long-term care insurance (LTCI) doesn't always have to come solely from current income. In many cases, repositioning part of your current assets can provide all or part of your LTC needs. The following assets are commonly repositioned.

ASSET INFORMATION		
Asset	Value	Owner
Retirement Accounts	$	
Roth Retirement Accounts	$	
Stocks & Bonds	$	
Checking & Savings	$	
CD or Money Market	$	
Life Insurance Cash Value	$	
HSA Account	$	
Do you own your home	$	

NON-QUALIFIED ANNUITY INFORMATION			
Annuity	Value	How much is gain?	Is the annuity owned by you or your spouse/partner?
Annuity 1	$	$	
Annuity 2	$	$	
Annuity 3	$	$	
Annuity 4	$	$	

If repositioning one of these types of assets doesn't match your objective, what annual or monthly amount of income could be budgeted towards meeting your LTC goal?

Annual Premium:	$	Monthly Premium	$

D. Certification

The undersigned hereby represents to CPS/Special Risk Services , that the information contained in this intake form is accurate and complete, and that the undersigned understands that CPS/Special Risk Services ,will rely on this information for purposes of obtaining quotes for Long-Term Care Insurance and/or other insurance products. The undersigned further understands and represents that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct and negative impact on his or her ability to obtain the desired coverage.

Dated: ________________________

Signature of Client or Client Representative: ____

By way of this letter,CPS/Special Risk Services , and its agents, iare not offering legal advice. The content outlined in this communication may not be suitable for every individual, in every state. As such, before employing or acting upon any one, or more, of the techniques, strategies, or opinions discussed in this letter, the reader should secure the services of a competent elder law attorney in their respective state. Furthermore, no inference is to be drawn that any of the insurance products provided by CPS/Special Risk Services , have been reviewed or approved by any state Medicaid office. CPS/Special Risk Services , makes no guarantee that the purchase of any insurance products will result in eligibility for Medicaid or any other assistance program.