

ASSET ANALYSIS FOR LONG TERM CARE PLANNING - SINGLE

Name:			Date:		
VALUE OF ASSETS OWNED, AND HOW TITLED					
NAME OF FINANCIAL INSTITUTION	Client	Joint with Survivorship	Other	Beneficiary Designations	Notes
Checking Accounts					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
Savings Accounts					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
Money Market Accounts					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
Cert's of Deposit					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		

Plan is only as accurate as the information provided.

Seen and Correct: _____
Please be thorough.

Firm is not retained to verify accuracy of information on the form.

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	Client	Joint with Survivorship	Other	Beneficiary Designations	Notes
Savings Bonds (Total)					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
Stocks & Bonds/Brokerage Acc'ts/Mutual Funds					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
Notes Receivable					
	\$	\$	\$		
	\$	\$	\$		
Non Tax-Deferred Annuities					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		
Business Interests					
	\$	\$	\$		
	\$	\$	\$		
Limited Partnerships					
	\$	\$	\$		

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	Client	Joint with Survivorship	Other	Beneficiary Designations	Notes
Real Estate (Tax Assessed Value)					
Life Estate	\$	\$	\$		
	\$	\$	\$		
Residence	\$	\$	\$		
	\$	\$	\$		
Time Share	\$	\$	\$		
	\$	\$	\$		
Investment/Rental Property	\$	\$	\$		
	\$	\$	\$		
Tax-Deferred Accounts					
Annuity	\$	\$	\$		
	\$	\$	\$		
IRA	\$	\$	\$		
	\$	\$	\$		
Vehicle 1	\$	\$	\$		
Vehicle 2	\$	\$	\$		
Value of Plots Owned	\$	\$	\$		
Funeral Arrangements	\$	\$	\$		
Pers. Prop. of Unusual Value	\$	\$	\$		
Other	\$	\$	\$		
Cash Value of Life Insurance					
	\$	\$	\$		
	\$	\$	\$		
	\$	\$	\$		

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GROSS INCOME PER MONTH					
	Client				
Social Security	\$				
Social Security Disability Income	\$				
Supplemental Security Income	\$				
Military Retirement	\$				
Civil Service Pension	\$				
	\$				
Other Pensions	\$				
	\$				
	\$				
	\$				
VA Disability	\$				
Rental Income	\$				
Alimony	\$				
Annuity Income	\$				
	\$				
Other	\$				
	\$				
TOTAL GROSS MONTHLY INCOME					

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GIFTS GIVEN OVER LAST FIVE YEARS	Approximate Date	Approximate Value	Notes		
		\$			
		\$			
Tithing/Charities		\$			
		\$			
		\$			
Family Gifts		\$			
		\$			
DEBTS OWED	Total Owed	Monthly Payment	Notes		
	\$	\$			
	\$	\$			
	\$	\$			
	\$	\$			
ESTIMATED MONTHLY MEDICAL EXPENSES					
	Client				
Medicare Premium	\$				
Supplemental Insurance Premium	\$				
Medicare Part D Premium	\$				
Recurring Prescriptions	\$				
Home Health Care	\$				
Adult Day Care	\$				
Nursing Home	\$				
Incontinence Supplies	\$				
Long Term Care Insurance	\$				
Other	\$				
TOTAL					

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