Long-Term Care Planning Assessment

Client Name	Date of Birth	Nicotine Usage (Yes or No & Type)	Height	Weight
#1: _____	_____	_____	_____	_____
#2: _____	_____	_____	_____	_____

Health Status & History: In the past 10 years, what conditions have you received medical advice, treatment, diagnosis, or consultation?

	#1 or #2
Cancer (other than skin) *	
Cardiac/Coronary Issues *	
Diabetes *	
Atrial Fibrillation	
Depression or Mental Disorder	
Chronic Pain or Disabling condition	
Epilepsy / Seizures	
Joint Replacement Surgery	
Osteoporosis / Osteopenia	
Rheumatoid Arthritis	
Strokes / TIAs	
Condition limiting motion	
A condition requiring adaptive device	
Other: _____	

Provide details for <u>any and all</u> conditions, with information about the physician(s), surgery, treatments, therapy, planned follow-ups, or medications taken (including over-the-counter), with the drug name, reason, dosage, and frequency.

CLIENT #1	CLIENT #2
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

* ***Provide Cancer, Cardiac and Diabetic details below***

Cancer	Type, location, and date of diagnosis: _____ Stage/Grade/Metastasis: _____ Dates/details of treatment and/or surgery: _____ Any recurrence and date of last follow-up: _____
Cardiac & Coronary	Date of diagnosis/Onset of chest pain: _____ Number of involved vessels: _____ Dates and details of treatment and/or surgery: _____ Date, type, and results of last testing: _____ Any symptoms since treatment/surgery: _____
Diabetes	Type: ☐ I or ☐ II Date of diagnosis: _____ Date/result of last A1c: _____ Treatment: ☐ Insulin ☐ Diet ☐ Medication Type and dosage: _____ Which of the following conditions have also been diagnosed? _____ 1 – Retinopathy 2 – Kidney Disease 3 – Neuropathy 4 – Heart Disease 5 – Hypertension 6 – Insulin Reaction 7– Microalbumin (Protein in Urine)

Plan Funding:

☐ Non-Qualified $ _____ ☐ One-Time ☐ 5–Pay ☐ 10-Pay ☐ 20-Pay ☐ Lifetime / Annual

☐ Qualified $ _____

☐ Cash Value from an Annuity: $ _____

☐ Cash Value from Life Insurance: $ _____

Lifestyle and Family Dynamics	CLIENT #1	CLIENT #2
Describe Your Build: Slim = 1 Athletic = 2 Muscular = 3 Oval/Pear = 4		
Ancestry: Europe = 1 Asia = 2 Africa = 3 India = 4 Latin America = 5 Middle East = 6 Other = 7		
How many times do you exercise 30+ minutes in a given week?		
How many servings of fruits and vegetables do you have every day?		
How many alcoholic drinks do you consume each day?		
Where do you turn for emotional support? (Select all that apply) Self = 1 Spouse = 2 Family = 3 Friends = 4		
How many doctor/dentist visits do you have in a given year?		
Family History of Cancer? (Select all that apply) None = 1 Self = 2 Family = 3 Type: _____		
Family History of Alzheimer's or Dementia? (Select all that apply) None = 1 Self = 2 Family = 3		
Family History of Diabetes? (Select all that apply) None = 1 Self = 2 Family = 3		
Family History of Heart Disease? (Select all that apply) None = 1 Self = 2 Family = 3		
Family History of Stroke? (Select all that apply) None = 1 Self = 2 Family = 3		
Planned/Actual Age of Retirement and State To Live During Retirement (Example 68 - FL)		
How many parents or grandparents lived to at least age 85:		

Authorization To Disclose Personal Medical Information

Under applicable state & federal law, including the Health Insurance Portability and Accountability Act (HIPAA), I give your firm and its agents/representatives access to and use of my protected health information for the purposes of the underwriting or administration of insurance coverage on my behalf. The information used in accordance with this authorization may be redisclosed by your firm and may no longer be protected by federal and state privacy laws.

By signing this form, I agree to the release, disclosure, and sharing of my medical information by your firm and its agents. I relieve them from all liability having to do with that disclosure. This authorization will expire 24 months from the date of your signature. I am entitled to a copy of this authorization form, and a digital copy of this authorization is as valid as the original.

I have the right to revoke this authorization, in writing, at any time, but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health and non-health information taken before the receipt of the notice.

Signatures of the insured, applicant, or legal representative	Date	Applicable State(s)	Phone Number