# Plan for Care

Written Plan of Care for _____ Date____/____/_____

Family / Friends to notify immediately _____

_____

Attorney / CPA / Trustee / Other _____

Banker / Financial Advisor(s) _____

What experience do you have with any family or friends needing care?

_____

Do you believe you could live a long life and need help from others for your care? ☐ YES ☐ NO

If no, please explain _____

You may never need care, but if you did:
How would it affect your family? (Physically, emotionally, financially)

_____

_____

Any other concerns? _____

_____

**If you ever need care, would you like to:**

- ☐ preserve your ability to choose
- ☐ decide now where you will receive care
- ☐ defer this decision until later
- ☐ defer this decision to someone else
  Who? _____

**Where would you want to receive care?**

- ☐ Your home
- ☐ Your child's home
- ☐ Assisted living facility
- ☐ Nursing home facility
- ☐ Other _____

**Who do you want to physically provide care?**

- ☐ Your spouse
- ☐ Your child
- ☐ A professional caregiver
- ☐ Other _____

**Who do you want to be responsible for coordinating your care?**

- ☐ Your spouse
- ☐ Your children
- ☐ A professional care coordination service
- ☐ Other _____





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**How will you generate the income every month to pay for your care needs?**

**1.** Which asset first? _____

**2.** Which asset next? _____

**3.** Which asset next? _____

**4.** Which asset next? _____

**5.** Which asset next? _____

**6.** Children / Family will pay for it.

**What other planning have you done?**

- ☐ Living will
- ☐ Health care directive
- ☐ Power of attorney
- ☐ Trust
- ☐ Other _____

## My policy information

### LTC

Carrier: Name, Address, Phone _____

Policy number, Primary Beneficiary(s) _____

Contingent Beneficiary(s) — if applicable _____

### Life Policies

Carrier: Name, Address, Phone _____

Policy number, Primary Beneficiary(s) _____

Contingent Beneficiary(s) — if applicable _____

### Annuity

Carrier: Name, Address, Phone _____

Policy number, Primary Beneficiary(s) _____

Contingent Beneficiary(s) — if applicable _____

| Printed Name, Relationship | Signature | Date (MM/DD/YYYY) |
|---|---|---|
| _____ | _____ | ____/____/_____ |
| _____ | _____ | ____/____/_____ |
| _____ | _____ | ____/____/_____ |
| _____ | _____ | ____/____/_____ |

**Note to Financial Professional:** Please file this document in your confidential client files and do not forward to the OneAmerica home office.





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