

Plan for care

Written plan of care for _____ Date: (MM) (DD) (YYYY)

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

Date (MM/DD/YYYY)

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