

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 who need 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 your 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: _____

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

Long-Term Care

Carrier: Name, Address, Phone number

Policy number, Primary Beneficiary(ies)

Contingent Beneficiary(ies) – if applicable

Life policies

Carrier: Name, Address, Phone number

Policy number, Primary Beneficiary(ies)

Contingent Beneficiary(ies) – if applicable

Annuity

Carrier: Name, Address, Phone number

Policy number, Primary Beneficiary(ies)

Contingent Beneficiary(ies) – if applicable

Printed name & relationship

Date: (MM) (DD) (YYYY)

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