

INCOME CAP TRUST INTAKE SHEET

Name of Elder: _____ Date of Birth: _____

Social Security # of Elder: _____ Relationship of Client to Elder: _____

Power of Attorney: *Yes / No* Date Signed: _____ Who Appointed: _____

Address of Elder: _____

County and length of residence there: _____

Type of Facility: Adult Foster Care Nursing Home
 Assisted Living Residential Care Facility
 In-Home Other: _____

Name of Client (Trustee): _____ Social Security #: _____

Address and Telephone Number of Client (*Include Relationship*) _____

Alternate Trustee: (*Name, Address, Relationship*) _____

Does Elder have Health Insurance? *Yes / No* Where: _____ Cost: \$ _____

Does Elder have Medicare Supplemental Insurance, or some alternative Managed Care? _____

Does Elder have Long Term Care Insurance? *Yes / No* Details: _____

Social Security Income of Elder: _____

Other Gross Income (specify): _____

Cost of Care per month (all but Medications):\$ _____ Cost of Medications per month:\$ _____

Assets of Elder: _____

Has any of this month's income been spent? _____ How much is left?? _____

Are there any unpaid debts, bills expected, etc...? _____

Where are Bank Accounts? _____

Are Bank Accounts JTWRROS*: *Yes / No* If Yes, with whom: _____

Is there a Social Security Representative Payee: *Yes / No* If Yes, who: _____

Spouse of Elder living? *Yes / No* Still in community? *Yes / No* Still in home? *Yes / No* Is

there a burial plan or life insurance in place for Elder: *Yes / No*

If so, where, and for how much: _____

If not, discuss whether to have one, how much to set aside, etc... _____

Is there a burial plan or life insurance in place for Spouse of Elder: *Yes / No*

If so, where, and for how much: _____

If not, discuss whether to have one, how much to set aside, etc... _____

Worker Name and Number: _____

* JTWRROS (Joint/Trust With Rights Of Survivorship)