Syndicate Subscription Legal Plans

ELDER LAW & ELDER PROTECTION CLIENT INTAKE QUESTIONNAIRE:

If an older adult is in immediate danger, call 911. To report suspected abuse, neglect, or exploitation, contact your county Adult Protective Services (APS). For abuse in a nursing home or care facility, contact the Long-Term Care Ombudsman. Eldercare Locator: 1-800-677-1116.

CONFIDENTIAL. Syndicate assists seniors and their families with estate and end-of-life planning, health care decision-making, asset protection and long-term care costs, benefits, and elder abuse. The senior is our client. If a family member or caregiver helps complete this form, we will also speak with the senior privately to confirm their wishes. If a question does not apply, write "N/A." If unknown, write "Unknown."

WHO IS COMPLETING THIS FORM:

[__] The senior [__] Spouse / partner

[__] Adult child / relative [__] Agent under power of attorney

[__] Conservator / guardian [__] Friend / caregiver

Name of person completing form: _____ Relationship: _____

Phone: _____ Email: _____

Syndicate Plan Member ID: _____ Plan Start Date: _____

Preferred method of contact:

[__] Phone [__] Text [__] Email [__] Mail

PART 1 — THE SENIOR

Full Legal Name: _____ Date of Birth: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Email: _____

1.1 Living arrangement:

[__] Own home [__] Rents

[__] Lives with family [__] Assisted living

[__] Nursing / skilled care facility [__] Other

Facility name (if any): _____

1.2 Marital status:

[__] Married [__] Registered domestic partner

[__] Widowed [__] Divorced

[__] Single

Spouse / partner name and age: _____

1.3 Primary language: _____ Hearing / vision / mobility needs: _____

1.4 Is the senior a military veteran (or surviving spouse of a veteran)? [__] Yes [__] No

1.5 Ability to manage finances and health decisions:

[__] Makes own decisions [__] Needs some help

[__] Needs significant help [__] Unable to make decisions

1.6 Has a doctor diagnosed dementia or a memory condition? [__] Yes [__] No

1.7 Primary doctor / phone: _____

PART 2 — HOW CAN WE HELP?

2.1 Check all that apply:

[__] Will / living trust

[__] Advance health care directive

[__] Asset protection / care costs

[__] Veterans benefits (Aid & Attendance)

[__] Care facility contract / discharge

[__] Reverse mortgage / home issues

[__] Elder abuse or neglect → Part 6

[__] Grandparent custody / visitation

[__] Durable power of attorney (finances)

[__] POLST / end-of-life wishes

[__] Medi-Cal / Medicaid planning

[__] Social Security / Medicare issues

[__] Quality of care complaint

[__] Conservatorship / guardianship *

[__] Scam / financial exploitation → Part 6

[__] Age discrimination (work / housing)

** For conservatorship, please also complete our Conservatorship Intake Form.*

2.2 In your own words, what is happening and what would you like to accomplish? _____

_____

_____

_____

PART 3 — EXISTING PLANNING DOCUMENTS

Document	Date Signed	Agent / Trustee Named	Where Kept
Will			
Revocable living trust			
Durable power of attorney (finances)			
Advance health care directive / health care POA			
POLST / DNR			
Beneficiary designations			
Long-term care insurance policy			

3.1 Does the senior want to change any of these documents? [__] Yes [__] No

If yes, explain: _____

_____

3.2 Has anyone pressured the senior to change documents or beneficiaries? [__] Yes [__] No

If yes, explain: _____

_____

PART 4 — FINANCES

4.1 Monthly Income:

Source	Monthly Amount $
Social Security	
Pension	
VA benefits	
Annuity / retirement distributions	
Rental / investment income	
Other	

4.2 Assets:

Asset (home, bank, investments, retirement, life insurance, vehicle)	Owner / Joint With	Est. Value $

4.3 Debts (mortgage, loans, credit cards): $ _____

4.4 Has the senior made gifts or transferred assets in the past 5 years? [__] Yes [__] No

If yes, explain: _____

_____

Gifts and transfers can affect eligibility for Medi-Cal / Medicaid long-term care benefits, which review past transfers (a "look-back" period).

4.5 Who currently helps manage the senior's finances? _____

PART 5 — LONG-TERM CARE & BENEFITS

5.1 Current or expected level of care:

[__] Independent [__] In-home help needed [__] Assisted living

[__] Memory care [__] Skilled nursing [__] Hospice

5.2 Monthly cost of care: $ _____ Paid by: _____

5.3 Current coverage:

[__] Medicare [__] Medi-Cal / Medicaid [__] Long-term care insurance

[__] VA benefits [__] Private pay [__] Family

5.4 Has an application for Medi-Cal / Medicaid or VA benefits been filed or denied? [__] Yes [__] No

If yes, explain: _____

_____

5.5 Has a facility issued a discharge, eviction, or transfer notice? [__] Yes [__] No

If yes, explain: _____

_____

5.6 Has a facility asked a relative to sign as guarantor? [__] Yes [__] No

PART 6 — ELDER ABUSE, NEGLECT & EXPLOITATION

Share only what you are comfortable sharing. We will discuss details privately.

6.1 Type of abuse or concern (check all that apply):

[__] Physical abuse (hitting, rough handling, restraint)

[__] Neglect (bedsores, falls, malnutrition, dehydration, poor hygiene)

[__] Emotional abuse (yelling, threats, humiliation)

[__] Isolation from family or friends

[__] Financial abuse (theft, forged checks, misuse of POA)

[__] Scam (phone, online, romance, investment, contractor)

[__] Sexual abuse

[__] Abandonment

[__] Self-neglect

6.2 Suspected person(s): _____ Relationship to senior: _____

6.3 Where:

[__] At home [__] Family member's home [__] Care facility

[__] Hospital [__] Online / phone

6.4 When did it start? _____

Is it still happening? [__] Yes [__] No

6.5 What happened (signs noticed, incidents, changes in behavior or finances): _____

_____

_____

_____

6.6 Financial Losses:

Date	Amount $	Taken By / Paid To	How (check, card, wire, gift card, crypto, deed)

6.7 Reported to:

[__] Adult Protective Services
[__] Long-Term Care Ombudsman
[__] Bank / financial institution
[__] Police
[__] State licensing agency
[__] Not yet reported

Report / case numbers: _____

6.8 Immediate help needed:

[__] Elder abuse restraining order
[__] Revoke power of attorney
[__] Recover money or property
[__] Change caregivers / facility
[__] Freeze accounts / alert bank
[__] Move senior to a safe place
[__] Remove an agent / trustee
[__] Other

Many states provide special protections and remedies for elder and dependent adult abuse, including restraining orders and recovery of damages and legal fees in some cases.

PART 7 — FAMILY & DECISION-MAKERS

Name	Relationship	Phone	Involved in Care / Finances?

7.1 Are there family disagreements about care or finances? [__] Yes [__] No

If yes, explain: _____

_____

7.2 Is there anyone the senior does NOT want involved or informed? [__] Yes [__] No

If yes, explain: _____

_____

PART 8 — GOALS & DOCUMENTS

8.1 The senior's goals:

[__] Stay at home as long as possible
[__] Leave an inheritance to family
[__] Choose trusted decision-makers
[__] Qualify for benefits
[__] Plan for long-term care costs
[__] Avoid probate
[__] Stop abuse and recover losses
[__] Peace of mind

Please provide copies of the following, if available. Check each item you are including.

[__] Wills / trusts / amendments
[__] Income statements (SSA, pension, VA)
[__] Deeds / property tax bills
[__] Facility admission agreement
[__] Evidence of abuse (photos, statements)
[__] Powers of attorney / health care directives
[__] Bank & investment statements
[__] Insurance policies (life, LTC)
[__] Benefit applications / denial letters
[__] APS / police reports

Authorization & Certification:

[__] I authorize Syndicate Subscription Legal Plans to communicate with the persons, agencies, and institutions named in this form regarding this matter.

I declare that the information provided in this questionnaire is true, correct, and complete to the best of my knowledge. I understand this information is provided to Syndicate Subscription Legal Plans in confidence for the purpose of evaluating this elder law matter.

Signed and dated this ____ day of _____, 20___

Signature (Senior): _____

Print Name: _____

Signature (Person Assisting): _____

Print Name: _____

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Your information will be reviewed within one hour.