

MEDICAID PLANNING QUESTIONNAIRE (Married)

This form is very important. Your accuracy and completeness in responding will help us represent you.

A. CLIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

E-Mail Address _____ Fax No. _____

B. PERSONAL INFORMATION

Husband

Wife

Full Name _____

(print names as they appear on your checks)

Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Husband

Wife

Birth Date _____

Social Security No. _____

U.S. Citizen? Yes No

U.S. Citizen? Yes No

Veteran? Yes No

Veteran? Yes No

Wartime? Yes No

Wartime? Yes No

Do you have a present disability that is service connected? Yes No

Do you have a present disability that is service connected? Yes No

C. CHILDREN (if applicable)

CHILD'S NAME	ADDRESS WITH ZIP CODE	TELEPHONE NUMBER	E-MAIL ADDRESS	SOCIAL SECURITY NUMBER
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Does the Husband have any children by a previous marriage?	Yes	No
Does the Wife have any children by a previous marriage?	Yes	No
Are any of your children disabled or receiving public benefits?	Yes	No
Do any of your children live with you?	Yes	No

If you answered "yes" to any of the above questions, please explain.

D. GRANDCHILDREN (if applicable)

How many grandchildren _____
 Are any grandchildren disabled? Yes No

E. MEDICAL INFORMATION

1. HEALTH

Name of Ill Spouse _____

Diagnosis _____

Prognosis _____

Course of Treatment _____

Activities of Daily Living (please check all which require assistance)

Feeding	_____	Toileting	_____
Dressing	_____	Medication	_____
Mobility	_____	Cognition	_____

Where Ill Spouse Currently Resides _____

Is this a nursing home? Yes No Date Entered _____

Is this an assisted living facility? Yes No Date Entered _____

If not, is placement imminent? Yes No

When _____

Where did Ill Spouse reside prior to NH or AL? _____

Name of Well Spouse _____

Health of Well Spouse _____

Where Well Spouse Currently Resides _____

Is this an assisted living facility? Yes No

If yes, date entered _____

2. PHYSICIANS

Husband

Name of Primary Physician _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Wife

Name of Primary Physician _____

Address _____

City _____ State _____ Zip _____

Telephone _____

3. IF UNDER 65:

Have you ever received SSI? Yes No

Have you ever received SSDI? Yes No

Have you ever had a disability
determination by a state agency? Yes No

F. MONTHLY INCOME

Husband's Gross Monthly Income

Wife's Gross Monthly Income

Social Security Benefits (gross)	\$ _____	\$ _____
Medicare Part B Deduction	<\$ _____ >	<\$ _____ >
Retirement Benefits*(gross)		
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
VA Benefit: Disability	\$ _____	\$ _____
Service related	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Investment Income	\$ _____	\$ _____
Other Income (identify source)	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____	\$ _____

*For any retirement benefits, including a pension, please list the gross benefit amount, including any monies taken out for federal income taxes, health insurance, dues or any other reason.

Do you expect the Retirement Benefits amount to increase in the future? Yes No
(other than cost of living increases)

G. MONTHLY COST OF NURSING HOME / ASSISTED LIVING (if applicable)

Monthly Nursing Home Cost	\$ _____
Monthly Prescription Cost	\$ _____
Monthly Incontinence Cost	\$ _____
Monthly Other Cost	\$ _____
Total Monthly Costs	\$ _____

The nursing home is paid through the month of _____

H. GIFTS

Please list any gifts made to an individual, a group of individuals or to a trust within the past 5 years:

Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____
Recipient _____	Date _____	Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

I. ASSETS

<u>Assets</u>	<u>Value</u>	<u>Titled</u>	<u>Institution/Bank</u>
Residence	\$ _____	_____	_____
Other Real Estate	\$ _____	_____	_____
Automobile	\$ _____	_____	_____
Additional Automobiles	\$ _____	_____	_____
Checking Accts.	\$ _____	_____	_____
	\$ _____	_____	_____
Savings Accts.	\$ _____	_____	_____
	\$ _____	_____	_____
Money Market Accts.	\$ _____	_____	_____
Certificates of Deposit	\$ _____	_____	_____
Brokerage Account	\$ _____	_____	_____
Mutual Funds Not Held by Broker	\$ _____	_____	_____
Stocks Not Held by Broker	\$ _____	_____	_____
Bonds Not Held by Broker	\$ _____	_____	_____
Annuities	\$ _____	_____	_____
Cash Value of Life Insurance	\$ _____	_____	_____
IRAs	\$ _____	_____	_____
401K or other tax-deferred acct.	\$ _____	_____	_____
Funeral/Burial Plan*	\$ _____	_____	_____
Promissory Notes	\$ _____	_____	_____
Business Interests	\$ _____	_____	_____
Copyrights or Royalties	\$ _____	_____	_____
OTHER _____	\$ _____	_____	_____
TOTALS	\$ _____	_____	_____

What did you pay for your current home, including any improvements? \$ _____

Address of any real property other than personal residence:

(1) Street _____

City _____ State _____ Zip _____

What did you pay for this property, including any improvements? \$ _____

(2) Street _____

City _____ State _____ Zip _____

What did you pay for this property, including any improvements? \$ _____

* If you have a funeral or burial plan, is the plan revocable or irrevocable?

J. LIABILITIES

	Amount of Liability
Mortgage	\$ _____
2 nd Mortgage	\$ _____
Line of Credit	\$ _____
Credit Cards	\$ _____
Auto Loan	\$ _____
Medical Bills	\$ _____
Tax Liabilities	\$ _____

K. LONG-TERM CARE INSURANCE

1. OWNER	COMPANY	POLICY NO.
_____	_____	_____
DAILY BENEFITS	BENEFIT LIMIT	PERIOD OF COVERAGE
_____	_____	_____
2. OWNER	COMPANY	POLICY NO.
_____	_____	_____
DAILY BENEFITS	BENEFIT LIMIT	PERIOD OF COVERAGE
_____	_____	_____

L. LIFE INSURANCE

Owner	Face Value	Cash Value
1. _____	_____	_____
Outstanding Loans	Beneficiary	Monthly Premiums/Deductibles
_____	_____	_____
Policy Number _____		
Owner	Face Value	Cash Value
2. _____	_____	_____
Outstanding Loans	Beneficiary	Monthly Premiums/Deductibles
_____	_____	_____
Policy Number _____		
Owner	Face Value	Cash Value
3. _____	_____	_____
Outstanding Loans	Beneficiary	Monthly Premiums/Deductibles
_____	_____	_____
Policy Number _____		

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

M. WILLS AND ADVANCE DIRECTIVES

Do you and your spouse have any of the following documents?

	<u>Husband</u>		<u>Wife</u>	
Last Will and Testament	Yes	No	Yes	No
General Power of Attorney (financial)	Yes	No	Yes	No
Power of Attorney for Health Care	Yes	No	Yes	No
Living Will	Yes	No	Yes	No
Trusts of any kind	Yes	No	Yes	No
Other, Please describe: _____				

N. REFERRAL

How were you referred to this office?

Name _____

Address _____

City _____ State _____ Zip _____

- OR Newspaper advertising
Yellow Pages advertising
Senior Blue Book
Other advertising _____

O. CERTIFICATION

The undersigned hereby represents to The Law Office of C. Jan Lord, LLC, and each of its attorneys, that the information contained in this intake form is accurate and complete to the best of my knowledge. The undersigned further understands that the law firm and its individual lawyers will rely on this information and that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative: _____