MEDICAID PLANNING QUESTIONNAIRE

Date ______________________________

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to your appointment.

If you are not married at this time, leave questions concerning your spouse blank.

1. PERSONAL DATA

(Husband) **(Wife)**

Full Name _________________________ Full Name ___________________________
Street Address ____
City __________________________________ State ____________ Zip _____________

Home Phone No. ____________________ Business Phone No. ___________________
E-mail Address _____________________ Fax No. ______________________________

(Husband) **(Wife)**

Birth Date _________________________ Birth Date ___________________________
Social Security No. __________________ Social Security No. ___________________

U.S. Citizen? Yes ☐ No ☐ U.S. Citizen? Yes ☐ No ☐
Veteran? Yes ☐ No ☐ Veteran? Yes ☐ No ☐
If your spouse is deceased, provide date of death: ______________________

2. MEDICAL DATA

Husband's Medical Condition (circle one)
Excellent Good Fair Poor Not alert

Primary Medical Problems (if any)
____
____
Has Husband already entered a nursing home? Y N
If yes, name of nursing home____
Date first entered nursing home_______________________
How long expected to remain in nursing home_____________________________________
If Husband is not in nursing home, how long until nursing home needed (circle one)
Less than 1 year 1-3 years 3-5 years More than 5 years

Wife's Medical Condition (circle one)
Excellent Good Fair Poor Not alert

Primary Medical Problems (if any)
____
____

Has Wife already entered a nursing home? Y N
If yes, name of nursing home______________________________
Date first entered nursing home_______________
How long expected to remain in nursing home______________________

If Wife is not in nursing home, how long until nursing home needed (circle one)
Less than 1 year 1-3 years 3-5 years More than 5 years

3. **CHILDREN (use additional sheets if necessary)**

Name of Child ______________________________
Street Address ______________________________
City ____________________ State __________ Zip __________
Home Phone Number ____________ Work Number ____________
Date of Birth ______________ Social Security Number ________
E-mail Address ______________________________

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Name of Child ______________________________
Street Address ______________________________
City ____________________ State __________ Zip __________
Home Phone Number ____________ Work Number ____________
Date of Birth ______________ Social Security Number ________
E-mail Address ______________________________

Name of Child ____

Street Address ____

City ______________________________ State ____________ Zip ____________

Home Phone Number ________________ Work Number _________________

Date of Birth ________________________ Social Security Number __________

E-mail Address ____

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 all of your children in good health? Yes ☐ No ☐

Are any of your children blind? Yes ☐ No ☐

Are any of your children disabled? Yes ☐ No ☐

Are any of you children receiving SSI or other gov't benefit Yes ☐ No ☐

Do any of your children live with you in your home? Yes ☐ No ☐

If yes, name of child ____

How long lived with you _________________

4. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$____________	$____________
Retirement Benefits	$____________	$____________
VA Disability Benefit	$____________	$____________
Annuity Income	$____________	$____________
Rental Income	$____________	$____________
Other (specify)	$____________	$____________
TOTAL MONTHLY INCOME	$____________	$____________

If there is a pension, please list the **gross pension amount**, before any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future? Yes ☐ No ☐

5. **MONTHLY SHELTER EXPENSES**

(Please divide to calculate monthly amounts)

Rent/Mortgage $____________________
Real Estate Taxes(divided by 12) $____________________
Water (divided by 6) $____________________
Sewer $____________________
Utilities (Gas & Electric) $____________________
Homeowner's insurance premium (divide by 12) $____________________
Condominium fees $____________________

Total Monthly Housing Expenses $____________________

6. **MONTHLY COST OF NURSING HOME**

Home $_____________________
Prescriptions $_____________________
Incontinent/Other Supplies $_____________________
Other $_____________________

Total Monthly Cost $_____________________

7. **ASSETS (Use extra sheets if necessary. List Owner as either Husband, Wife, or Joint.)**

REAL PROPERTY (Bring Deeds and recent Tax Bills)

Address, City, State, Zip	Owner	Value	Loan Amount

CASH ACCOUNTS (Bring recent statements for each account)

Name of Institution	Owner	Amount

INVESTMENT ACCOUNTS (Bring recent statements for each account)

Name of Brokerage Firm	Owner	Amount

VEHICLES AND BOATS (Bring Registrations or Titles)

Type of Vehicle (Year and Make)	Owner	Value

RETIREMENT PLANS (Bring recent statements for each account)

Company name	Owner	Value

LIFE INSURANCE POLICIES (Bring original policies or recent statements)

Company:
Policy #:
Insured:
Owner:
Face Amount:
Cash value:

Company:
Policy #:
Insured:
Owner:
Face Amount:
Cash value:

ANNUITIES (Bring Policies or recent statements for each Annuity)

Company:
Acct. Number:
Owner:
Value:

Company:
Acct. Number:
Owner:
Value:

OTHER ASSETS (do not list personal effects or household furnishings)

Description	**Owner**	**Value**

Do you have a pre-paid Funeral? Yes ☐ No ☐
(If yes, bring your contract papers.)

Do you have Long Term Care Insurance? Yes ☐ No ☐
(If yes, bring your contract papers.)

<u>DOCUMENTS TO BRING WITH YOU</u>

Current Wills or Trusts
Powers of Attorney
Living Wills/Health Care Powers of Attorney
Deeds for all Real Estate
Most recent Tax Bill for all Real Estate
Recent Statement for all Bank accounts
Recent Statement for all Brokerage accounts
Recent Statement for all Retirement Plans (IRA, 401K, etc.)
Copies of Stock Certificates and Bonds you hold
Copies of Registration or Title for all vehicles and boats
Life Insurance Policies
Long term care Insurance Policies
Annuity Contracts
Papers for any Businesses you own
Prepaid Funeral papers
Papers for any other assets you own
Most recent Income Tax Return

8. GIFTS

Have you made any gifts to anyone in the past 5 years?

Yes ☐ No ☐

If yes, list below:

Recipient ____________________ Date __________ Amount _________
Recipient ____________________ Date __________ Amount _________
Recipient ____________________ Date __________ Amount _________
Recipient ____________________ Date __________ Amount _________

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

If so, please state details ______________________________________
____

9. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes ☐ No ☐
If yes, please explain ____
____
____

10. REFERRAL

Who Referred You To This Office?
Name ____
Phone ____

☐ Attorney ☐ Financial Planner

☐ Previous Client of Your Firm ☐ Doctor

☐ Social Worker ☐ Other _____________

11. CERTIFICATION

The undersigned hereby represents to Edwin J. Lowry, Jr. that the information contained in this intake form is accurate and complete, and that the undersigned understands that the attorney will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the attorney may not be appropriate.

Signature of Client or Client Representative

____

Printed Name: _______________________