

**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.**

**1. PERSONAL DATA**

Full Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax No. \_\_\_\_\_

U.S. Citizen? Yes  No

Veteran? Yes  No

If your spouse is deceased, provide date of death: \_\_\_\_\_

**2. MEDICAL DATA**

**Your Medical Condition (circle one)**

Excellent      Good      Fair      Poor      Not alert

Primary Medical Problems (if any)

\_\_\_\_\_

Have you 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 you are not in a nursing home, how long until nursing home will probably be 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 \_\_\_\_\_

**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 \_\_\_\_\_

**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 \_\_\_\_\_

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**

Your  
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 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)      \$ \_\_\_\_\_

Home maintenance      \$ \_\_\_\_\_

Condominium fees      \$ \_\_\_\_\_

Prescription Drugs      \$ \_\_\_\_\_

Medical insurance      \$ \_\_\_\_\_

Car insurance      \$ \_\_\_\_\_

Life Insurance      \$ \_\_\_\_\_

Clothing      \$ \_\_\_\_\_

Food      \$ \_\_\_\_\_

Gas for car \$ \_\_\_\_\_  
 Car payment \$ \_\_\_\_\_  
 Entertainment \$ \_\_\_\_\_  
 Miscellaneous \$ \_\_\_\_\_  
 Other \$ \_\_\_\_\_  
**Total Monthly Expenses** \$ \_\_\_\_\_

**6. MONTHLY COST OF NURSING HOME (if in home at this home)**

Home \$ \_\_\_\_\_  
 Prescriptions \$ \_\_\_\_\_  
 Incontinent/Other Supplies \$ \_\_\_\_\_  
 Other \$ \_\_\_\_\_  
**Total Monthly Cost** \$ \_\_\_\_\_

**7. ASSETS (Use extra sheets if necessary. List Owner as either Individual or Joint with another person.)**

**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)**

<b>Name of Brokerage Firm</b>	<b>Owner</b>	<b>Amount</b>

**VEHICLES AND BOATS (Bring Registrations or Titles)**

<b>Type of Vehicle (Year and Make)</b>	<b>Owner</b>	<b>Value</b>

**RETIREMENT PLANS (Bring recent statements for each account)**

<b>Company name</b>	<b>Owner</b>	<b>Value</b>

**LIFE INSURANCE POLICIES (Bring original policies or recent statements)**

<b>Company:</b>
<b>Policy #:</b>
<b>Insured:</b>
<b>Owner:</b>
<b>Face Amount:</b>
<b>Cash value:</b>

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<b>Insured:</b>
<b>Owner:</b>
<b>Face Amount:</b>
<b>Cash value:</b>

**ANNUITIES (Bring Policies or recent statements for each Annuity)**

<b>Company:</b>
<b>Acct. Number:</b>
<b>Owner:</b>
<b>Value:</b>

<b>Company:</b>
<b>Acct. Number:</b>
<b>Owner:</b>
<b>Value:</b>

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

<b>Description</b>	<b>Owner</b>	<b>Value</b>

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.)

**DOCUMENTS TO BRING WITH YOU**

- 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 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 \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Attorney                     | <input type="checkbox"/> Financial Planner |
| <input type="checkbox"/> Previous Client of Your Firm | <input type="checkbox"/> Doctor            |
| <input type="checkbox"/> Social Worker                | <input type="checkbox"/> 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: \_\_\_\_\_