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MEDICAID PLANNING QUESTIONNAIRE

Confidentiality: The following information will be held in the strictest confidence. Please complete the questionnaire as thoroughly and as accurately as possible.

Date Completed_____

Part I—Personal Information of Client and Spouse

Full Legal Name			
Social Security Number			
Date of Birth			
Legal Address			
County of Residence		Date of Marriage	
Home Phone	Cell Phone		Cell Phone
Highest Grade Completed			
Does the Client File Taxes	Yes___ No___ Jointly___		Yes___ No___ Jointly____
Is the Client a Veteran	Yes___ No___		Yes___ No___

Part II—Prior Hospital Information

Has the nursing home client spent 30 consecutive nights institutionalized for medical purposes since September 30, 1989? If so, give the hospital name and date of admission of that stay. _____

If the nursing home client was in a hospital prior to entering the nursing home, please list the following:

Name of Hospital_____
Address_____
Date First Entered_____ Date Discharged_____

Part III—Nursing Home Client Information

Please answer the following questions regarding the client or spouse who is currently in a nursing home or contemplates entering a nursing home:

Name of Nursing Home: _____

Date first entered: _____

Diagnosis: _____ Prognosis: _____

Course of Treatment : _____

Is the client able to understand and sign documents? Yes ____ No ____

Part IV – Insurance Information

Name of **Supplemental** Health Insurance Company:

Nursing Home Spouse _____ Monthly Premium:_____
Community Spouse _____ Monthly Premium:_____

Name of **Prescription** Insurance Company:

Nursing Home Spouse _____ Monthly Premium:_____
Community Spouse _____ Monthly Premium:_____

Does the nursing home client have nursing home/long term care insurance?
Yes____ No____ If so, please furnish a copy of the nursing home insurance policy.

Part V—Client Income Information

Please include ***gross*** monthly income information. (Before taxes and deductions.)

Income Source	**Nursing Home Client's Monthly *Gross* Amount**	**Community Spouse's Monthly G*ross A*mount**
Salary or Wages		
Social Security Benefits		
Railroad Retirement Benefits		
Retirement Benefits		
Veterans Benefits		
Rental Income		
Other		
TOTAL INCOME		

Part VI—Client Gifting

Has either spouse made a gift of cash or an asset worth in excess of $1,000 in value to an individual other than the other spouse within the past 5 years? If so, please complete the following:

Recipient_____ Date_____ Value $_____

Recipient_____ Date_____ Value $_____

Recipient_____ Date_____ Value $_____

Recipient_____ Date_____ Value $_____

Recipient_____ Date_____ Value $_____

Part VII—Client Asset Information

List the approximate value of each asset or liability (debt).

Type of Asset	Company	Account Number	Owner(s) on Account	Value
Checking Accounts				
Savings Accounts				
Other Bank Accounts				
Certificates of Deposit				
IRA's/401K				
Nursing Home Account				
Mutual Funds				
Stocks				
Bonds				
Annuities				
Life Insurance				
Business Interest				
Residential Real Estate				
Other Real Estate				
Automobile				
Additional Automobile(s)				
Safety Deposit Box				
Prepaid Funeral(s)				
Other				

Are there any loans on any of the assets:_____
If Yes, please explain: _____

Part VIII—Client Estate Planning Information

Does either spouse have any of the following estate planning documents in place?

a)	Last Will and Testament	Husband ___	Wife ___
b)	Living Revocable Trust	Husband ___	Wife ___
c)	Durable Power of Attorney	Husband ___	Wife ___
	If so, who is the Agent?	For Husband_____	
		For Wife_____	
d)	Living Will or Health Care Power of Attorney	Husband ___	Wife ___
	If so, who is the Agent?	For Husband_____	
		For Wife_____	
e)	Prepaid Funeral Trust	Husband ___	Wife ___
		Amount $_____	Amount $_____

NOTE: Please provide copies of all executed estate planning documents listed above.

Part IX—Referral Information

We like to thank those who are kind enough to refer new clients to our office. Please provide the name, address, and telephone number of the person who referred you to this office.

Name_____
Address_____
Phone No._____

If you were not referred to our office, how did you find us?
_____

Part X—Client's Children's Information

Child's Legal Name & Social Security #	**Full Address**	**Telephone # & Email Address**	**Parent**
			Husband (_) **Wife (_)** **Both (_)**
			Husband (_) **Wife (_)** **Both (_)**
			Husband (_) **Wife (_)** **Both (_)**
			Husband (_) **Wife (_)** **Both (_)**
			Husband (_) **Wife (_)** **Both (_)**
			Husband (_) **Wife (_)** **Both (_)**
			Husband (_) **Wife (_)** **Both (_)**

Do any of your children live with you in your home? Yes ___ No ___
If so, who? _____ Since when? _____
Is this child disabled? Yes ____ No ____

Do you have any predeceased children? Yes _____ No _____
For predeceased children, please list their name(s) and the name(s) of their children, if applicable:

Child: _____ their children _____
_____
_____

Child: _____ their children _____
_____
_____