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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 1- Personal Information of Client

Full Legal Name:

Mr./Ms._____

Social Security Number:_____

Date of Birth:_____Age:_____

Legal Address:_____

County of Residence:_____

Home Phone:_____Cell or Other Phone:_____

Is client widowed: Yes____ No____ *If widowed please provide a copy of death certificate

Is client divorced: Yes____ No____ *If divorced please provide copy of divorce decree

Highest Grade Level Completed:_____

Does the client file taxes: _____

Is the client a Veteran: _____

Part II: Prior Hospital Information

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 who is currently in a nursing home or is contemplating 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____

Is the client in a Medicaid approved bed? Yes____ No____

What is the daily private pay room rate? _____

Part IV-Insurance Information

Name of **Supplemental Health Insurance Company:**_____
Premiums Paid By: Check ____ Automatic Bank Transfer____

Amount $_____(annually, semi-annually, monthly)

Name of **Prescription Insurance Company:**_____
Premiums Paid By: Check ____ Automatic Bank Transfer____

Amount $_____(annually, semi-annually, monthly)

Does the nursing home client have nursing home/long-term care insurance?

Yes____ No____ If yes, please include a copy of the insurance policy.

Part V- Client Income Information

Please list below **gross (before taxes and deductions)** monthly income. Funds deposited into bank accounts may not be gross income.

Income Source	**Nursing Home Client's Monthly *Gross* Income**
Salary or Wages	
Social Security Benefits	
Railroad Retirement Benefits	
Retirement Benefits	
Veterans Benefits	
Rental Income	
Other	
Total Income	

Part VI – Client Gifting
Has the individual made a gift of cash or of an asset valued in excess of $1,000 to an individual other than the other spouse within the last five years? This includes the transfer of properties or assets for less than fair market value.

(Note: In the event, a spouse made a gift, in the last five years, please disclose below.

Recipient:_____ Date:_____ Value $_____

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). Indicate whether the asset is owned individually, or jointly, by entering the value under the appropriate owner. Provide the name(s) of the other joint owner(s). List the name of the bank or company where the asset is held.

Type of Asset	Company & Account #	$ Value
Checking Accounts		
Savings Accounts		
Nursing Home Account		
Other Bank Accounts		
Certificates of Deposit		
IRA/401K		
Mutual Funds		
Stocks		
Bonds		
Annuities		
Life Insurance		
Business Interest		
Residential Real Estate		
Other Real Estate		
Automobile		
Additional Automobiles		
Safety Deposit Box		
Prepaid Funeral		
Other		

Does the client have loans on any of the assets: _____
If Yes, please explain: _____

Part VIII- Client Estate Planning Information

Does the individual have any of the following estate planning documents?

a) Last Will and Testament Yes____ No____

b) Living Revocable Trust Yes____ No____

c) Durable Power of Attorney Yes____ No____
If yes, who is the Agent?
_____

d) Living Will or Health Care
Power of Attorney Yes____ No____
If yes, who is the Agent?
_____

e) Prepaid Funeral Trust Yes____ No____

Please provide copies of all executed estate planning documents.

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 Number:_____

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

Part X- Client's Children Information

Child's Legal Name	Full Address	Phone & Email

Do any of your children live with you in your home? Yes____ No____
If yes, who?_____
How long has he or she lived in your home?_____

Do you have any predeceased children? Yes____ No____
If yes, please list their name(s) and the name(s) of their children.

Child:_____ Their Children:_____
_____
_____

Child:_____ Their Children:_____
_____
_____