MEDICAID PLANNING QUESTIONNAIRE (SINGLE)

Please complete the following questionnaire to the best of your ability. This information is to assist us in making the appropriate recommendations for your planning based on your unique circumstances. Please mark n/a if the question does not apply to you. We will review this information at our meeting. ***The client is the person for whom planning is being implemented.***

DO NOT BE CONCERNED IF YOU CANNOT COMPLETE ALL OF THE QUESTIONS

A. PERSONAL DATA

1. **Client Name**
Full Name_____

If you have ever gone by any other name, please indicate:_____

Birth Date_____ Social Security No._____

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐ ☐If yes, VA No._____

Street Address_____

City_____ State_____ Zip_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Fax: _____ Work Fax: _____ E mail: _____

Date and Place of Marriage:_____

Are you living apart from your spouse? Yes ☐ No ☐

If yes, is it a legal separation? Yes ☐ No ☐

Have you been married previously? Yes ☐ No ☐

If you are currently in a health care facility:

Name of facility_____

Address_____

Type of facility_____ Level of care_____

Date of Admission_____

If you entered this facility from *another* health care facility, date of your admission to the *initial* facility_____

Mental Health Status_____

Physical Health Status_____

Current source of payments your care_____

B. FAMILY

2. **Name(s) of child(ren) – Include those living and deceased – If deceased put "D" next to the name with a date of death.**

Name_____ DOB_____ Marital Status_____

Address_____

Phone (day)_____(evening)_____

Name_____ DOB_____ Marital Status_____

Address_____

Phone (day)_____(evening)_____

Name_____ DOB_____ Marital Status_____

Address_____

Phone (day)_____(evening)_____

Name_____ DOB_____ Marital Status_____

Address_____

Phone (day)_____(evening)_____

3. List any special medical, educational, or other extraordinary personal or financial needs of any of the children_____
_____

4. Are all of your children in good health? Yes ☐ No ☐

5. Are any of your children blind? Yes ☐ No ☐

If so, identify and include age_____

6. Are any of your children disabled? Yes ☐ No ☐

If so, identify the child, age and disability_____

7. Have all of your children completed their education? Yes ☐ No ☐

8. Are any of your children receiving SSI or other form of government entitlement? Yes ☐ No ☐

9. Is anyone dependent upon the you for support? If so, please identify the person, and provide some general information as to the reason for, and extent of, support provided:

_____
_____
_____

10. Do any of your family members have any problems with:

AIDS?	Yes ☐	No ☐
Drug Addiction?	Yes ☐	No ☐
Alcoholism?	Yes ☐	No ☐
Spendthrift?	Yes ☐	No ☐

11. Do any of your children live with you in your home? Yes ☐ No ☐
If yes, name of child_____

12. Does a parent, sibling or other family member currently live in your home? Yes ☐ No ☐

If you answered Yes, how long has he/she lived with you? _____

If you answered Yes, is any portion of your income directly or indirectly used to provide all or a portion of his/her support? Yes ☐ No ☐

C. ASSETS

13. Insurance – If more space is required, attach a separate sheet of paper.

COMPANY (include address and policy #)	TYPE (Whole or Term)	FACE AMOUNT	CASH VALUE	INSURED	BENEFICIARY

14. **List your property with estimated fair market values in the broad categories provided. If owned jointly with another person, provide name and relationship of co-owner.**

Family Residence	**Value**	**Ownership**
Primary Residence (Tax Assessed) Purchase Price $_____	$_____	_____
Other Real Estate Location: _____ _____		
Tax assessed value: Purchase Price $_____	$_____	_____

Other Real Estate
Location: _____
_____
Tax assessed value: $_____ _____
Purchase Price $_____

	Value	Ownership
General Household		
Furniture:	$_____	_____
Furnishings:	$_____	_____
Household effects of special value		
(china, silver, antiques, works of art,	$_____	_____
collections, etc.)	$_____	_____
Automobile(s)		
#1 Year: _____	$_____	_____
Make: _____		
Loan balance:$_____		
#2 Year: _____	$_____	_____
Make: _____		
Loan balance:$_____		

Bank Savings or Money Market Accounts
Account No. _____ Bank: _____ Amt. $_____Ownership:_____
Account No. _____ Bank: _____ Amt. $_____Ownership:_____
Account No. _____ Bank: _____ Amt. $_____Ownership:_____

Bank Checking Accounts
Account No. _____ Bank: _____ Amt. $_____Ownership:_____
Account No. _____ Bank: _____ Amt. $_____Ownership:_____
Account No. _____ Bank: _____ Amt. $_____Ownership:_____

Bank Certificates of Deposit
Account No. _____ Bank: _____ Amt. $_____Ownership:_____
Account No. _____ Bank: _____ Amt. $_____Ownership:_____
Account No. _____ Bank: _____ Amt. $_____Ownership:_____

Mutual Funds
Fund name: _____Current value:$_____ Ownership:_____
Fund name: _____Current value:$_____ Ownership:_____
Fund name: _____Current value:$_____ Ownership:_____
Fund name: _____Current value:$_____ Ownership:_____

Stocks and Bonds
(Name): _____Current Value:$_____ Ownership:_____
(Name): _____Current Value:$_____ Ownership:_____
(Name): _____Current Value:$_____ Ownership:_____
(Name): _____Current Value:$_____ Ownership:_____

IRAs, Keoghs, 401K plans, annuities
Type of Plan: _____Current Value:$_____ Ownership:_____Beneficiary:_____

Type of Plan: _____Current Value:$_____ Ownership:_____Beneficiary:_____
Type of Plan: _____Current Value:$_____ Ownership:_____Beneficiary:_____
Type of Plan: _____Current Value:$_____ Ownership:_____Beneficiary:_____

Business interests
(such as limited partnership, realty trusts, ownership of closely held corporation, royalty rights, etc)
Describe:_____

Prepaid Funeral Plan (if applicable)
Burial account: _____
Burial insurance: _____
Plot: _____
Headstone: _____
Is the plan ____ Revocable or ____ Irrevocable

15. Do you have any accounts designated as Pay On Death (POD) or Transfer On Death (TOD)?
Yes ☐ No ☐

If Yes, indicate which account(s) and to whom the account is payable to:_____

16. If you have any joint accounts, indicate date account was established and with whom_____
_____

17. If joint owner on any account is anyone other than a spouse, indicate whose funds were used to establish the account and dates and amounts of any deposits made by the other joint owners_____
_____

18. Are you the beneficiary of any trust? Yes ☐ No ☐☐

If yes, please enclose a copy of the signed version or provide any terms and conditions of the trust of which you are aware.

19. **Other assets** (other than life insurance)
_____
_____
_____

20. Please list any monies *owed* to you:

From Whom:_____ Amount owed to you:_____
From Whom:_____ Amount owed to you:_____

21. Do either of you expect to inherit significant property or have a "power of appointment" under anyone else's will or trust? Yes ☐ No ☐☐
If yes, please explain:_____

D. <u>INCOME & EXPENSES</u>

22. **Please list all sources of income on a monthly basis (if income is annual or in some other format please convert to a monthly amount). Please use *gross amounts* without any deductions.**

Monthly Income

Work Earnings $_____

Social Security Retirement	$_____
Social Security Disability	$_____
Supplemental Social Security	$_____
Veterans' Benefits	$_____
Private Pension	$_____
Annuity Income	$_____
Public Employment Pension	$_____
Railroad Retirement	$_____
Support from Spouse	$_____
Regular Support from Others	$_____
Unemployment Compensation	$_____
Workers' Compensation	$_____
Regular Income from Trust	$_____
Rental Income	$_____
Interest and Dividends	$_____
IRA, 401K or Keogh	$_____
Other Income	$_____
TOTAL MONTHLY INCOME	$_____

23. **MONTHLY SHELTER EXPENSES**

How much do you pay each month for:

Rent/Mortgage	$_____	(including interest/principal)
Property Taxes	$_____	(divide annual cost by 12)
Homeowners'/Renters' Insurance	$_____	
Condo/HOA Fee	$_____	
Heat	$_____	
Electricity	$_____	
Water	$_____	
Phone	$_____	
TOTAL MONTHLY SHELTER EXPENSES	$_____	

24. **MONTHLY NON-SHELTER LIVING EXPENSES (ESTIMATED)**

Food (Including dining out & groceries)	$_____
Medical (dental treatment, therapy, vision treatment, prescriptions, hearing aides, home health aides, medical appliances)	$_____
Clothing	$_____
Health Insurance Premiums	$_____
Life Insurance Premiums	$_____
Cable TV	$_____
Federal & State Income Taxes	$_____
Home Maintenance (snow removal, yard care, etc.)	$_____
Transportation (auto insurance, auto club, repairs, gas, registration, parking fees, etc.)	$_____
Other	$_____
TOTAL MONTHLY NON-SHELTER EXPENSES	$_____

25. **MONTHLY COST OF NURSING HOME**

$_____	Monthly Nursing Home Cost
$_____	Monthly Prescription Cost

$_____ Monthly Incontinent Cost
$_____ Monthly Other Cost

$_____ **Total Monthly Nursing Home Costs**

The nursing home is paid through _____(month/year).

E. MISCELLANEOUS

26. Please provide the name, address and policy numbers for all your health insurance, including Medicare Part A, Part B, Part C and Part D, Medicaid, long term care insurance, and private health insurance.

_____
_____
_____

27. GIFTS

Please list gifts made in excess of $1,000.00 in any one month, to an individual or group of individuals, within the past 60 months (5 years) or to a trust during the last 60 months. List any gifts of any amount made since February 8, 2006. Include charitable contributions.

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

28. Have you ever made gifts totaling more than $11,000.00 in one calendar year? Yes ☐ No ☐

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

If so, please state details_____
_____

30. Have you, during the last 90 days, had substantial medical expenses, such as nursing home or hospital bills, which have not been paid and are not expected to be paid by Medicare, long-term care insurance, or other insurance? Yes ☐ No ☐
If yes, please provide details:_____

31. List your own debts, if any, other than any mortgage:

To Whom:_____ Amount Due:_____
To Whom:_____ Amount Due:_____
To Whom:_____ Amount Due:_____

32. Is there any expected change in your circumstances in the next five years? For example, are you involved in a lawsuit, could have a significant change in health or financial status, or any other major changes? If so, provide details:_____
_____

33. Do you have any other legal issues which I should be aware of? Yes ☐ No ☐

If yes, please explain _____
_____

34. Name, address and phone number of your insurance agent: _____
_____

35. Name, address and phone number of your financial advisor:_____
_____

36. Do you want us to contact either your insurance agent or financial advisor to let them know you have met with us? Yes ☐ No ☐☐

F. REFERRAL

37. By Whom Were You Referred To This Office?

Name_____

Street Address_____

City_____ State_____ Zip_____

G. ADDITIONAL INFORMATION

Please see the attached supplemental questionnaire. If you are changing language, beneficiaries or representatives in any existing estate planning documents or if you require new estate planning documents, please complete the attached supplementation questionnaire.

H. CERTIFICATION

The undersigned hereby represents to Law Offices of Mindy Felinton PC and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand 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: Date:

_____ _____

_____ _____