MEDICAID PLANNING QUESTIONNAIRE
-SINGLE-

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

Date _____

A. PERSONAL DATA

Full Name _____
(print name as shown on your checks)

Home Phone No._____ Business Phone No._____
Extension: ____

E-mail Address_____ Fax No._____

Street Address_____

City _____ State _____ Zip Code _____

Birth Date_____ Social Security No. _____

U.S. Citizen? Yes ☐ No ☐ Veteran? Yes ☐ No ☐

If widowed, please list date of death of spouse

Was your former spouse a Veteran? Yes ☐ No ☐

B. MEDICAL DATA

1. HEALTH

Diagnosis

Prognosis

Course of Treatment

If you are already in a nursing home, please indicate the name of the nursing home and the date first entered

Name of Nursing
Home_____

Address_____

Telephone No. _____Date Entered Facility _____

If you are in an Assisted Living Facility, please indicate name of facility and date first entered.

Name of Assisted Living
Facility_____

Address _____

Telephone Number_____

Date Entered Facility_____

2. ***PHYSICIAN***

Full Name of Primary Physician

Street Address

City_____ State_____ Zip _____

STATE PHARMACEUTICAL PLAN

Are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or any other state pharmaceutical plan? Yes ☐ No ☐

Are you currently on Senior Gold? Yes ☐ No ☐

4. HEALTH INSURANCE

Name of Health Insurance Company_____

Is this a Medicare Supplement Policy? Yes ☐ No ☐

Monthly Premium_____

5. LONG TERM CARE INSURANCE

Do you have long term care insurance? Yes ☐ No ☐

Name of Company_____

Monthly Premium_____

C. MONTHLY INCOME

Social Security Benefits (include $ Medicare Part B Deduction, if applicable)	$_____
Retirement Benefits (Gross)	$_____
Veterans Disability Income	$_____
Annuity Income	$_____
Rental Income	$_____
TOTAL MONTHLY INCOME	$_____

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

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

Do not include interest and dividend income on this form.

D. *MONTHLY COST OF NURSING HOME*

Monthly Nursing Home Cost $_____

Monthly Prescription Cost $_____

Monthly Incontinent Cost $_____

Monthly Other Cost $_____

Total Monthly Cost $_____

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

E. *GIFTS*

Have you made gifts in excess of $3,000 in any one month, to an individual or group of individuals, within the past 60 months, or to a trust within the past 60 months? Yes ☐ No ☐

If yes, list below:

Recipient_____ Date _____ Amount _____

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

F. *LIFE INSURANCE*

*Name of Insurance Company*_____ Policy #

Street Address

City_____ State_____ Zip

Type of Policy_____ Owner

Insured_____ Beneficiary

Death Benefit: $_____ Face Value: $_____ Cash Value: $

*Name of Insurance Company*_____ Policy #

Street Address

City_____ State_____ Zip

Type of Policy_____ Owner

Insured_____ Beneficiary

Death Benefit: $_____ Face Value: $_____ Cash Value: $

*Name of Insurance Company*_____ Policy #

Street Address

City_____ State_____ Zip

Type of Policy_____ Owner

Insured_____ Beneficiary

Death Benefit: $_____ Face Value: $_____ Cash Value: $

*Name of Insurance Company*_____ Policy #

Street Address

City_____ State_____ Zip

Type of Policy_____ Owner

Insured_____ Beneficiary

Death Benefit: $_____ Face Value: $_____ Cash Value: $

G. *CHILDREN*

Name of Child

Street Address

City_____ State_____ Zip

Phone Number_____ E-mail Address

Date of Birth_____ Social Security Number

Name of Child

Street Address

City_____ State_____ Zip

Phone Number_____ E-mail Address

Date of Birth_____ Social Security Number

Name of Child

Street Address

City_____ State_____ Zip

Phone Number_____ E-mail Address

Date of Birth_____ Social Security Number

Name of Child

Street Address

City_____ State_____ Zip

Phone Number_____ E-mail Address

Date of Birth_____ Social Security Number

Name of Child

Street Address

City_____ State_____ Zip

Phone Number_____ E-mail Address

Date of Birth_____ Social Security Number

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 your children receiving SSI or other form of government entitlement? Yes ☐ No ☐

Do any of your family members have any problems with:

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

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

If yes, name of child

Does a sibling live in your home with you? Yes ☐ No ☐

If yes, name of sibling

ASSETS/LIABILITIES

Please insert the value of each asset in the appropriate space.

ASSET/LIABILITY	ASSET TOTAL	NAME ON ACCOUNT
PERSONAL EFFECTS		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK#_____ LOT#_____ (Obtain from Tax Bill)		
OTHER REAL ESTATE		
AUTOMOBILE(S)		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
IRA		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
TOTAL		

Do you have any liabilities? Please list

_____

_____
_____

What did you pay for your current home including any improvements? $

Address of any real property other than personal residence:

(1)Street _____City _____State_____Zip

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $

(2)Street _____City _____State_____Zip

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $

Name of Homeowner's Insurance Company

Street Address

City_____ State_____ Zip

Phone No._____ Policy No.

MISCELLANEOUS

Do you have any other legal issues that I should be aware of: Yes ☐ No ☐

If yes, please explain

_____

I. ***REFERRAL***

By Whom Were You Referred To This Office?

Name

Street Address

City_____ State_____ Zip

J. CERTIFICATION

The undersigned hereby represents to Jo-Anne Herina Jeffreys, P.C., 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:

_____