MEDICAID PLANNING QUESTIONNAIRE (Married)

This form is very important. Your accuracy and completeness in responding will help us represent you.

A. CLIENT INFORMATION

Name ______________________________ Date ______________

Address ______________________________

City ____________________ State ________ Zip __________

Home Phone No. ____________________ Business Phone No. ______________

E-Mail Address ____________________ Fax No. ______________

B. PERSONAL INFORMATION

Husband | Wife

Full Name ____________________ | ____________________

(print names as they appear on your checks)

Address ______________________________

City ____________________ State ________ Zip __________

Home Phone No. ____________________ Business Phone No. ______________

Husband			Wife		
Birth Date ______________			______________		
Social Security No. ______________			______________		
U.S. Citizen?	Yes	No	U.S. Citizen?	Yes	No
Veteran?	Yes	No	Veteran?	Yes	No
Wartime?	Yes	No	Wartime?	Yes	No
Do you have a present disability that is service connected?	Yes	No	Do you have a present disability that is service connected?	Yes	No

C. CHILDREN (if applicable)

CHILD'S NAME	ADDRESS WITH ZIP CODE	TELEPHONE NUMBER	E-MAIL ADDRESS	SOCIAL SECURITY NUMBER

Does the Husband have any children by a previous marriage? Yes No
Does the Wife have any children by a previous marriage? Yes No
Are any of your children disabled or receiving public benefits? Yes No
Do any of your children live with you? Yes No
If you answered "yes" to any of the above questions, please explain.

____

____

D. GRANDCHILDREN (if applicable)

How many grandchildren ____________________

Are any grandchildren disabled? Yes No

E. MEDICAL INFORMATION

1. HEALTH

Name of Ill Spouse ____________________________

Diagnosis ____

Prognosis ____

Course of Treatment ____

Activities of Daily Living (please check all which require assistance)

Feeding	_________	Toileting	_________
Dressing	_________	Medication	_________
Mobility	_________	Cognition	_________

Where Ill Spouse Currently Resides ____

Is this a nursing home? Yes No Date Entered ______________

Is this an assisted living facility? Yes No Date Entered ______________

If not, is placement imminent? Yes No

When ____________________

Where did Ill Spouse reside prior to NH or AL? ________________________________

Name of Well Spouse ___________________________

Health of Well Spouse ____

Where Well Spouse Currently Resides ____

Is this an assisted living facility? Yes No

If yes, date entered ____________________

2. PHYSICIANS

Husband

Name of Primary Physician ______________________________

Address ____

City ______________________ State ______ Zip _________

Telephone ____________________

Wife

Name of Primary Physician ______________________________

Address ____

City ______________________ State ______ Zip _________

Telephone ____________________

3. IF UNDER 65:

Have you ever received SSI? Yes No

Have you ever received SSDI? Yes No

Have you ever had a disability determination by a state agency? Yes No

F. MONTHLY INCOME

	Husband's Gross Monthly Income	Wife's Gross Monthly Income
Social Security Benefits (gross)	$________	$________
Medicare Part B Deduction	<$________>	<$________>
Retirement Benefits*(gross)		
________	$________	$________
________	$________	$________
________	$________	$________
VA Benefit: Disability	$________	$________
Service related	$________	$________
Annuity Income	$________	$________
Rental Income	$________	$________
Investment Income	$________	$________
Other Income (identify source)	$________	$________
________	$________	$________
________	$________	$________
TOTAL MONTHLY INCOME	$________	$________

*For any retirement benefits, including a pension, please list the gross benefit amount, including any monies taken out for federal income taxes, health insurance, dues or any other reason.

Do you expect the Retirement Benefits amount to increase in the future? Yes No
(other than cost of living increases)

G. MONTHLY COST OF NURSING HOME / ASSISTED LIVING (if applicable)

Monthly Nursing Home Cost	$________
Monthly Prescription Cost	$________
Monthly Incontinence Cost	$________
Monthly Other Cost	$________
Total Monthly Costs	$________

The nursing home is paid through the month of ________

H. GIFTS

Please list any gifts made to an individual, a group of individuals or to a trust within the past 5 years:

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

I. ASSETS

Assets	Value	Titled	Institution/Bank
Residence	$________	________	________
Other Real Estate	$________	________	________
Automobile	$________	________	________
Additional Automobiles	$________	________	________
Checking Accts.	$________	________	________
	$________	________	________
Savings Accts.	$________	________	________
	$________	________	________
Money Market Accts.	$________	________	________
Certificates of Deposit	$________	________	________
Brokerage Account	$________	________	________
Mutual Funds Not Held by Broker	$________	________	________
Stocks Not Held by Broker	$________	________	________
Bonds Not Held by Broker	$________	________	________
Annuities	$________	________	________
Cash Value of Life Insurance	$________	________	________
IRAs	$________	________	________
401K or other tax-deferred acct.	$________	________	________
Funeral/Burial Plan*	$________	________	________
Promissory Notes	$________	________	________
Business Interests	$________	________	________
Copyrights or Royalties	$________	________	________
OTHER ________	$________	________	________
TOTALS	$________	________	________

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 _______

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

(2) Street ____

City _________________________ State _________ Zip ______

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

* If you have a funeral or burial plan, is the plan revocable or irrevocable?

____

J. LIABILITIES

	Amount of Liability
Mortgage	$_______________
2nd Mortgage	$_______________
Line of Credit	$_______________
Credit Cards	$_______________
Auto Loan	$_______________
Medical Bills	$_______________
Tax Liabilities	$_______________

K. LONG-TERM CARE INSURANCE

1. OWNER	COMPANY	POLICY NO.
________	________	________
DAILY BENEFITS	BENEFIT LIMIT	PERIOD OF COVERAGE
________	________	________
2. OWNER	COMPANY	POLICY NO.
________	________	________
DAILY BENEFITS	BENEFIT LIMIT	PERIOD OF COVERAGE
________	________	________

L. LIFE INSURANCE

	Owner	Face Value	Cash Value
1.	________	________	________
	Outstanding Loans	Beneficiary	Monthly Premiums/Deductibles
	________	________	________
	Policy Number ________		
	Owner	Face Value	Cash Value
2.	________	________	________
	Outstanding Loans	Beneficiary	Monthly Premiums/Deductibles
	________	________	________
	Policy Number ________		
	Owner	Face Value	Cash Value
3.	________	________	________
	Outstanding Loans	Beneficiary	Monthly Premiums/Deductibles
	________	________	________
	Policy Number ________		

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

M. WILLS AND ADVANCE DIRECTIVES

Do you and your spouse have any of the following documents?

	Husband		**Wife**	
Last Will and Testament	Yes	No	Yes	No
General Power of Attorney (financial)	Yes	No	Yes	No
Power of Attorney for Health Care	Yes	No	Yes	No
Living Will	Yes	No	Yes	No
Trusts of any kind	Yes	No	Yes	No

Other, Please describe: ____

N. REFERRAL

How were you referred to this office?
Name____
Address ____
City______________________ State _______ Zip _______

OR Newspaper advertising
Yellow Pages advertising
Senior Blue Book
Other advertising ________________

O. CERTIFICATION

The undersigned hereby represents to The Law Office of C. Jan Lord, LLC, and each of its attorneys, that the information contained in this intake form is accurate and complete to the best of my knowledge. The undersigned further understands that the law firm and its individual lawyers will rely on this information and 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: ______________________________