

2. PHYSICIAN

Full Name of Husband's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

Full Name of Wife's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

3. PHARMACEUTICAL PLANS

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior GOLD? Yes No

If you are a Pennsylvania resident, are you currently receiving benefits under PACE? Yes No

If you re a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? Yes No

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits (include \$58.70 Medicare Part B Deduction, if applicable)	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
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 SHELTER EXPENSES
(Please divide annual expenses by 12 and quarterly expenses by 3)

Rent/Mortgage \$ _____

Real Estate Taxes \$ _____

Water \$ _____

Sewer \$ _____

Utilities (Heat, Electric & Telephone)
(1/12th of last 12 months) \$ _____

Homeowner's insurance premium \$ _____

Condominium fees \$ _____

Total Monthly Housing Expenses \$ _____

E. MONTHLY NON-SHELTER LIVING EXPENSES

Food \$ _____

Medical \$ _____

Clothing \$ _____

Transportation (including auto insurance) \$ _____

Home Maintenance \$ _____

Life Insurance Premiums \$ _____

Health Insurance Premiums \$ _____

Cable TV \$ _____

Federal and State Income Taxes \$ _____

Other \$ _____

Total Monthly Non-Shelter Living Expenses \$ _____

F. GIFTS

Have you made gifts in excess of \$5,000 in any one month, to an individual or group of individuals, within the past 36 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 _____

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

If so, please state details

G. CHILDREN (if applicable)

Name of Child _____
Street Address _____
City _____ State _____ Zip _____
Home Phone Number _____ Work Phone Number _____
Date of Birth _____ Social Security Number _____
E-mail Address _____

Name of Child _____
Street Address _____
City _____ State _____ Zip _____
Home Phone Number _____ Work Phone Number _____
Date of Birth _____ Social Security Number _____
E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Date of Birth _____ Social Security Number _____

E-mail Address _____

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 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

J. CERTIFICATION

The undersigned hereby represents to James DeMartino, 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:

MEDICAID PLANNING -ADDITIONAL INFORMATION

Last Name of Client _____

File No. _____

A. ASSETS/LIABILITIES

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING				
SAVINGS				
MONEY MARKET				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ EQ. RT _____ REM. FCTR _____				
OTHER REAL ESTATE BLOCK# _____ LOT# _____ EQ. RT _____ REM. FCTR _____				
ADDITIONAL AUTOMOBILES				

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
BROKERAGE/CAP ACCOUNTS				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA/RETIREMENT PLANS				
NURSING HOME DEPOSIT				
PREPAID FUNERAL				
OTHER:				
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 _____

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. _____

B. 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).

C. 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: \$ _____