

# MEDICAID PLANNING QUESTIONNAIRE (SINGLE)

Date \_\_\_\_\_

Home Phone No. \_\_\_\_\_

E-mail Address \_\_\_\_\_

Version of Software:     WordPerfect             Word

File No. \_\_\_\_\_

Business Phone No. \_\_\_\_\_

Fax No. \_\_\_\_\_

Other \_\_\_\_\_

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

## A. PERSONAL DATA

Full Name \_\_\_\_\_  
(print name as shown on your checks)

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

U.S. Citizen?    Yes     No

Veteran?    Yes     No

If widowed, please list name of spouse and date of death \_\_\_\_\_

Was your former spouse a Veteran?    Yes     No

If you or your former spouse is or was a Veteran, are you receiving Tricare?    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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2. PHYSICIAN**

Full Name of 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**

Social Security Benefits (include \$58.70 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. 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

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**E.    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 \_\_\_\_\_

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 \_\_\_\_\_

**F. MISCELLANEOUS**

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

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**G. REFERRAL**

By Whom Were You Referred To This Office?

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

- Referral is a:
- |   |  |
|---|--|
| <input type="checkbox"/> Attorney                           | <input type="checkbox"/> Financial Planner |
| <input type="checkbox"/> Previous Client of James DeMartino | <input type="checkbox"/> Doctor            |
| <input type="checkbox"/> Social Worker                      | <input type="checkbox"/> Other _____       |

Have you visited our Website at [www.njelderlawfirm.com](http://www.njelderlawfirm.com)? Yes  No

Do you have any ideas for improving our Website? If so, please discuss.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**H. 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**

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

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING		
SAVINGS		
MONEY MARKET		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ EQ. RATIO _____ REM. FCTR _____		
OTHER REAL ESTATE BLOCK# _____ LOT# _____ EQ. RATIO _____ REM. FCTR _____		
AUTOMOBILE(S)		
BROKERAGE/CAP ACCOUNTS		

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
IRA/RETIREMENT PLANS		
NURSING HOME DEPOSIT		
PREPAID FUNERAL		
OTHER:		
OTHER:		
OTHER:		
<b>TOTAL</b>		

**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: \$ \_\_\_\_\_