MEDICAID PLANNING QUESTIONNAIRE
(MARRIED)

Date____ File No._______________________________________
Home Phone No._____________________________________ Business Phone No.______________________________
E-mail Address______________________________________ Fax No.____
Version of Software: WordPerfect Word Other____

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.

A. PERSONAL DATA

(Husband)
Full Name____
(print name as shown on your checks)

(Wife)
Full Name____
(print name as shown on your checks)

Street Address____

City____ State_________________ Zip__________________

(Husband)
Birth Date____

Social Security No.____________________________________

U.S. Citizen? Yes No

Veteran? Yes No

(Wife)
Birth Date____

Social Security No.____________________________________

U.S. Citizen? Yes No

Veteran? Yes No

If you or your spouse is a Veteran, are you receiving Tricare? Yes No

B. MEDICAL DATA

1. HEALTH

Name of Ill Spouse____

Diagnosis____

Prognosis____ Course of Treatment____________________________

If Ill Spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis____

Name of Well Spouse____

Where Well Spouse Currently Resides____

Health of Well Spouse____

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

If yes, name of child____

H. MISCELLANEOUS

Do you have any other legal issues which 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____________

Referral is a:

Attorney

Previous Client of James DeMartino

Social Worker

Financial Planner

Doctor

Other____________________

Have you visited our Website at www.njelderlawfirm? Yes No

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

____

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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. <u>ASSETS/LIABILITIES</u>

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. <u>MONTHLY COST OF NURSING HOME</u>

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: $__________

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