MEDICAID PLANNING QUESTIONNAIRE
(SINGLE)

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. 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

_____

_____

_____

E. <u>CHILDREN</u> (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: □ Attorney □ Financial Planner

□ Previous Client of James DeMartino □ Doctor

□ Social Worker □ Other_____

Have you visited our Website at 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. <u>ASSETS/LIABILITIES</u>

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:		
TOTAL		

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: $_________________

j:\hotdocs\w-assets.mps
Rev. 2/20/2003