



MEDICAID PLANNING QUESTIONNAIRE

(Married or Single)
If single, complete only as one.

Date _____ File No _____

Home Phone _____ Business Phone _____

E-mail address _____ Fax No. _____

Version of Software: Workperfect 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, or mail, fax, or e-mail it to us prior to our meeting time.

A. PERSONAL DATA

Husband (or Single Man)

Wife (or Single Woman)

Full Name _____

Full Name _____

(print name as shown on your checks)

(print name as shown on your checks)

Street Address _____

City _____ State _____ Zip _____

Husband (or Single Man)

Wife (or Single Woman)

Birth Date _____

Birth Date _____

Soc. Sec. No. _____

Soc. Sec. No. _____

U. S. Citizen? Yes No

U. S. Citizen? Yes No

Veteran? Yes No

Veteran? Yes No

B. MEDICAL DATA

MEDICAL DATA

1. HEALTH

Name of Spouse _____

Diagnosis _____

Prognosis _____ Course of Treatment _____

If Ill Spouse already has 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/Single Man's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

Full Name of Wife/Single Woman's Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

3. STATE PHARMACEUTICAL PLAN

Are you currently on any state pharmaceutical plan? Yes No

C. MONTHLY INCOME

	<u>Husband/Single Man's Monthly Income</u>	<u>Wife/Single Woman's Monthly Income</u>
Social Security (Gross)	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefits (Gross)	\$ _____	\$ _____
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 other reason.

Could this pension amount increase in the future: Yes No

Do not include interest and dividend income in 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, and Telephone)	\$ _____
(1/12 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 equal to or in excess of \$2,000 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 _____

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 No. _____ Wk. Phone No. _____

Date of Birth _____ Soc. Sec. No. _____

E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Wk. Phone No. _____

Date of Birth _____ Soc. Sec. No. _____

E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Wk. Phone No. _____

Date of Birth _____ Soc. Sec. No. _____

E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Wk. Phone No. _____

Date of Birth _____ Soc. Sec. No. _____

E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Wk. Phone No. _____

Date of Birth _____ Soc. Sec. No. _____

E-mail Address _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Home Phone No. _____ Wk. Phone No. _____

Date of Birth _____ Soc. Sec. No. _____

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 receiving SSI or other form of governmental entitlement? Yes No

Do any of your family members have any problems with:

AIDs? Yes No

Drug Addition? Yes No

Alcoholism? Yes No

Spendthrift? Yes No

Does 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 of which I should be aware? Yes No

If yes, please explain _____

I. LEGAL DOCUMENTS

Which of the following documents do you currently have in place? (Check all that apply.)

- Prenuptial (pre-marriage) Agreement Yes No
- Revocable Trust (Dated _____) Yes No
 - Is Trust Joint with Spouse? Yes No
 - Is Trust Separate from Spouse? Yes No
- Last Will (Dated _____) Yes No
- Health Care Power of Attorney (Dated _____) Yes No

- Financial Power of Attorney (Dated _____) Yes No
- Advance Directive for Health Care (Living Will)
(Dated _____) Yes No
- Advance Directive for Mental Health
(Dated _____) Yes No
- Do Not Resuscitate (“DNR”) (Dated _____) Yes No
- Other (Describe _____) Yes No

J. REFERRAL

By whom were you referred to this office?

Name _____

Street Address _____

City _____ State _____ Zip _____

- Referral is a: Attorney Financial Planner
- Doctor Previous Client of Barber & Bartz
- Social Worker Other _____

Have you visited our Website? Yes No

Do you have any ideas for improving our Website? Yes No

If so, please discuss _____

K. CERTIFICATION

The undersigned hereby represents to Barber & Bartz, 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 attorneys, 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				
ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
RESIDENCE (ASSESSED VALUE) BLOCK # _____ LOT # _____ EQ. TR _____ REM. FCTR _____				
OTHER REAL ESTATE BLOCK # _____ LOT # _____ EQ. TR _____ REM. FCTR _____				
ADDITIONAL AUTOMOBILES				

BROKERAGE/CAP ACCOUNTS				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
CASH VALUE – LIFE INS.				
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 estate 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? _____

(3) 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 _____

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 No.** _____

Street Address _____

City _____ State _____ Zip _____

Insured _____ Beneficiary _____

Death Benefit \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy No.** _____

Street Address _____

City _____ State _____ Zip _____

Insured _____ Beneficiary _____

Death Benefit \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy No.** _____

Street Address _____

City _____ State _____ Zip _____

Insured _____ Beneficiary _____

Death Benefit \$ _____ Face Value \$ _____ Cash Value \$ _____

Name of Insurance Company _____ **Policy No.** _____

Street Address _____

City _____ State _____ Zip _____

Insured _____ Beneficiary _____

Death Benefit \$ _____ Face Value \$ _____ Cash Value \$ _____

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