# MONK LAW FIRM, PLLC

# MEDICAID PLANNING QUESTIONNAIRE

Date: \_\_\_\_\_

#### **CONTACT INFORMATION FOR PRIMARY CONTACT.**

In most situations when we are asked to help with Medicaid planning and Medicaid applications, our primary point of contact is not the actual client. More often than not, it is the child or loving caregiver who seeks our legal assistance for their parent or loved one. Please provide the following contact information for the person who will be the designated point of contact with our firm:

Name & Relationship:	
Primary Phone #:	
Alternate Phone #:	
Mailing Address:	
Email:	

#### PERSONAL INFORMATION FOR CLIENT.

In this section, please provide the information below about the person for whom our firm will provide legal services. All of the information requested in this form is vital, so please complete all parts of this form. If information is not available or not applicable to you, simply write "not available" or "N/A" in the space provided.

Full Name (Person #1)    Birth Date			Date		
Street Address					
		Zip			
Social Security No		U. S. Citizen? Yes / No	Veteran?	Yes / No	
Married? □ Yes ( □ No	if yes, provid	le spouse's information below)			
Full Name (Spouse)			Bir	th Date	_
Street Address					
City		State		Zip	
Social Security No		U. S. Citizen? Yes / No	Veteran?	Yes / No	

### **MEDICAL DATA FOR CLIENT**

Diagnosis:
Prognosis:
Treatment Plan:
Currently Resides:
If individual has already entered a nursing home, please provide the following:
Name of Nursing Home:
The first date entered on a continuous basis
MEDICAL DATA FOR SPOUSE

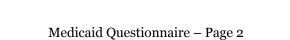
Diagnosis:	 	
Prognosis:	 	
Treatment Plan:		
Currently Resides:	 	
-		

If individual has already entered a nursing home, please provide the following:

Name of Nursing Home: \_\_\_\_\_

The first date entered on a continuous basis \_\_\_\_\_

# PLEASE PROVIDE ANY OTHER RELEVANT MEDICAL INFORMATION:



## **MONTHLY INCOME**

	Client Monthly Income	Spouse Monthly Income
Social Security Benefit (Please provide <b>gross</b> amount)	\$	\$
Retirement Benefit (Gross)	\$	\$
VA Disability Benefit	\$	\$
Annuity Income	\$	\$
Interest Income	\$	\$
Rental Income	\$	\$
Dividend Income	\$	\$
Total Monthly Income	\$	\$

## **MONTHLY EXPENSES**

	Client	Spouse
Monthly Cost of Nursing Home	\$	\$
Monthly Incidental Cost	\$	\$
Monthly Prescription Cost	\$	\$
Other Monthly Cost	\$	\$
Total Monthly Expenses	\$	\$

The Client's nursing home is paid through	(month/year).
The Spouse's nursing home is paid through	(month/year).

**MONTHLY SHELTER EXPENSES** (Please divide annual expenses by 12, and quarterly expenses by 3.)

	Client	Spouse
Rent/Mortgage	\$	\$
Real Estate Taxes	\$	\$
Water	\$	\$
Utilities (Heat, Electric, Etc.)	\$	\$
Homeowner's Insurance Premium	\$	\$
Condominium Fees	\$	\$
Total Monthly Expenses	\$	\$

### **MONTHLY NON-SHELTER EXPENSES** (Please estimate)

\$ Food
\$ Medical
\$ Clothing
\$ Telephone
\$ Transportation (including auto insurance)
\$ Home Maintenance
\$ Life Insurance Premiums
\$ Health Insurance Premiums
\$ Medicare Supplemental Insurance Premiums
\$ Cable TV
\$ Federal and State Income Taxes
\$ Other
\$ Total Monthly Non-Shelter Living Expenses

**ASSETS/LIABILITIES** (Please insert the value of each asset/liability in the appropriate space.)

Asset	Value	Liability
AUTOMOBILE		
ADDITIONAL AUTOMOBILE		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICIATES OF DEPOSIT		
RESIDENCE		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
IRA		
OTHER REAL ESTATE		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
TOTALS	\$	\$

**LIFE INSURANCE** (Copies of all policies must be provided to attorney)

COMPANY	TYPE	DEATH	FACE	CASH	INSURED	OWNER	BENEFICIARY
NAME		BENEFIT	VALUE	VALUE			
(include		VALUE					
address and							
policy #)							

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

**<u>GIFTS</u>** [For Medicaid purposes, a "gift" is not only where you give something to a friend or loved one for birthday or other holiday, but also any other transfer of property to a person for less than fair market value. If you aren't sure whether a transfer should be included, then you should assume that it should be listed below and discussed with the attorney.]

Please list gifts made in excess of \$100 in any one month, to an individual or group of individuals, within the past 60 months (Use separate page if necessary):

Recipient	Date	Ppty Transferred/Amount	
Recipient	Date	Ppty Transferred/Amount	
Recipient	Date	Ppty Transferred/Amount	
Recipient	Date	Ppty Transferred/Amount	
Recipient	Date	Ppty Transferred/Amount	
Recipient	Date	Ppty Transferred/Amount	
Recipient	Date	Ppty Transferred/Amount	
Recipient	Date	Ppty Transferred/Amount	
e you ever filed a Federal Gift Tax	Return? Yes	□ No □	

## **<u>CHILDREN</u>** (if applicable)

Have

CHILD'S NAME	ADDRESS (With Zip Code)	TELEPHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Are all of your children in good health? If answer is no, who?	Yes 🗆	No 🗆
Are any of your children receiving SSI or other forms of government entitlement? If answer is yes ,who?	Yes 🗆	No 🗆
Do any of your children live with you in your home? If answer is yes ,who?	Yes 🗆	No 🗆
Do all of your children get along? If answer is no, explain:	Yes 🗆	No 🗆

#### **CERTIFICATION**

The undersigned hereby represents to Monk Law Firm, PLLC that the information contained in this intake form is accurate and complete, and that the undersigned understands that Monk Law Firm, PLLC will rely on this information for purposes of developing a Medicaid plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Medicaid eligibility.

Dated: \_\_\_\_\_

Signature of Client or Client Representative:

Confidentiality Notice: E-mail or facsimile transmission is not a secure form of communication; therefore, e-mail or fax transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. The sender therefore accepts liability for any errors or omissions in the contents of the message, which arise as a result of e-mail or fax transmission.