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 _____

Street Address_____

City_____ State_____ Zip_____

Social Security No. _____-____-_____U. S. Citizen? Yes / No Veteran? Yes / No

Married? □ Yes (if yes, provide spouse's information below)
□ No

Full Name (Spouse) _____ Birth 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 ***gross*** 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 NAME (include address and policy #)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

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.

GIFTS [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_____

Have you ever filed a Federal Gift Tax Return? Yes ☐ No ☐

CHILDREN (if applicable)

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

Are all of your children in good health? Yes ☐ No ☐
If answer is no, who? _____

Are any of your children receiving SSI or other forms of government entitlement? Yes ☐ No ☐
If answer is yes ,who? _____

Do any of your children live with you in your home? Yes ☐ No ☐
If answer is yes ,who? _____

Do all of your children get along? Yes ☐ No ☐
If answer is no, explain: _____
_____

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.