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**MEDICAID/ASSET PROTECTION QUESTIONNAIRE**

**Please complete and bring with you to your consultation**

**CLAIMANT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Claimant’s Full Legal Name (*first, middle, last*) | | | | | |
| Your date of birth | | Place of birth | | Claimant’s Social Security Number  **-****-** | |
| Spouse’s Full Legal Name (*first, middle, last*) | | | | | |
| Spouse’s Date of Birth | | Spouse’s Place of Birth | | Spouse’s Social Security Number  **-****-** | |
| Date of marriage | | Place of marriage | | Date of death/divorce (*if applicable*) | |
| Address where mail should be sent: (*including city, state and zip code*) | | | | | |
| Address where claimant currently resides: (*including city, state and zip code*) | | | | | |
| Does claimant currently reside in a nursing home or assisted living facility? | | | | | Yes  No |
| Name of nursing home or facility: |  | | | | |
| Claimant’s phone number  **(****)** **-** | | | Spouse’s phone number  **(     )      -** | | |
| Claimant’s Email: | | | Spouse’s Email: | | |
| Is claimant a veteran? Yes  No | | | Branch of Service: | | |
| Is claimant’s spouse a veteran? Yes  No | | | Branch of Service: | | |

**HEALTH/DISABILITY INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Has claimant been hospitalized in the last 12 months? | | | | Yes  No | |
| Name and address of facility: | |  | | | |
|  | | | | | |
| Date Admitted: |  | | Release Date: | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name and address of facility: | |  | | |
|  | | | | |
| Date Admitted: |  | | Release Date: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please list names and address of all physicians providing care to claimant:** | | | | |
| Name: |  |  | Address: |  |
|  | | | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  |  | Address: |  |
|  | | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please check all that apply:** | | | |
| **Claimant** | **Spouse** |  |  |
|  |  |  | Housebound? |
|  |  |  | Disabled or incapacitated? Or declared incompetent? |
|  |  |  | Needs assistance performing basic daily activities? |
|  |  |  | Under 65, declared disabled by Social Security Administration? |
|  |  |  | Applied for/Receiving Medicaid? Type: |
|  |  |  | Diagnosed with dementia/Alzheimer’s? Stage:  Early  Mid  Late |
|  |  |  | Has muscular degeneration? Extent: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please list how much you are paying out of pocket for the following:** | | | | |
|  | **Claimant** |  | **Spouse** |
| In-Home Care Services: | $ |  | $ |
| Assisted Living Facility: | $ |  | $ |
| Health Insurance (NOT Medicare): | $ |  | $ |
| Long Term Care Premiums: | $ |  | $ |
| Doctor’s co-pays: | $ |  | $ |
| **Total unreimbursable expenses**: | $ |  | $ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please list your/spouse’s monthly medical/prescription out-of-pocket expenses:** | | | | |
|  |  | **Claimant** |  | | **Spouse** |
|  |  | $ |  | | $ |
|  |  | $ |  | | $ |
|  |  | $ |  | | $ |
|  |  | $ |  | | $ |

|  |  |
| --- | --- |
| **Does the claimant or spouse have prepaid burial insurance or burial plans?** Yes  No  If yes, please explain: | |
|  | |
|  | |
|  | |

**INCOME AND ASSET INFORMATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please list regular sources of monthly income and amounts:** | | **Claimant** |  | **Spouse** |
| Social Security: | $ |  | $ |
| Pension: | $ |  | $ |
| Other: | $ |  | $ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Will claimant or spouse receive income in the next 12 months from any of the following?** | | | | |
| Business operation or rental property | | Yes  No |
| Farm operation | | Yes  No |
| Personal injury settlement | | Yes  No |
| Anticipated inheritance | | Yes  No |
| Other: |  | | | |

|  |  |
| --- | --- |
| **Are there any one-time or non-monthly income sources the claimant expects to receive in the next 12 months?** Yes  No  If yes, please explain: | |
|  | |
|  | |
|  | |

**YOUR ASSETS**

Please provide us with an estimate of the value of your estate by completing the following schedule. Use your **best estimate** of each asset’s value, assuming you could cash it in or sell it today at a fair price. Disregard what you paid for the asset or what it was worth when you inherited it.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ASSET | VALUE IN  YOUR NAME | VALUE IN  SPOUSE’S NAME | VALUE IN JOINT NAMES W/ SPOUSE | AMOUNT OF DEBT ON ASSET |
| Real Estate: Homestead |  |  |  |  |
| Real Estate: Investment |  |  |  |  |
| Money Owed to You |  |  |  |  |
| Business |  |  |  |  |
| Death Benefit of Life Insurance |  |  |  |  |
| Annuities |  |  |  |  |
| IRAs and other Retirement Plans |  |  |  |  |
| Brokerage Accounts/ Mutual Funds |  |  |  |  |
| Individually-held Stocks & Bonds |  |  |  |  |
| Checking, Savings, Money Market |  |  |  |  |
| Vehicles, Boats & Planes |  |  |  |  |
| Household Goods |  |  |  |  |
| Other Personal Effects |  |  |  |  |
| Other |  |  |  |  |
| **Totals** |  |  |  |  |