HERITAGE
ELDER LAW & ESTATE PLANNING, LLC.

A Veteran Owned Law Firm

Detailed Medicaid Planning Worksheet

Individual filling out the form: _____

Date the form was filled out: _____

All information provided is strictly confidential.

Please complete these forms and return prior to your appointment.

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Referral: _____ ***Please fill out as accurately and fully as possible***

PERSONAL DATA

Client 1 Information:

Legal Name (First, MI, Last): _____ ☐ Sr. ☐ Jr. ☐ I ☐ II ☐ III

Gender: ☐ Male ☐ Female Date of Birth: _____ ☐ US Citizen ☐ Naturalized Citizen ☐ Resident Alien

Marital Status: ☐ Single ☐ Widowed (DoD: _____) ☐ Married (Date of Marriage: _____) ☐ 1st ☐ 2nd

☐ Divorced (Date of Divorce: _____) ☐ Separated Social Security Number: _____ Veteran: ☐ Yes ☐ No

Address: _____
Street Address City County State Zip Code

Home Phone: _____ Cell Phone: _____ Email Address: _____

In Skilled Nursing Facility? ☐ Yes ☐ No If **YES**, date of placement: _____

Name of Facility: _____

Address of Facility: _____
Street Address City County State Zip Code

Client 2 Information: Relationship to Client 1: _____

Legal Name (First, MI, Last): _____ ☐ Sr. ☐ Jr. ☐ I ☐ II ☐ III

Gender: ☐ Male ☐ Female Date of Birth: _____ ☐ US Citizen ☐ Naturalized Citizen ☐ Resident Alien

Marital Status: ☐ Single ☐ Widowed (DoD: _____) ☐ Married (Date of Marriage: _____) ☐ 1st ☐ 2nd

☐ Divorced (Date of Divorce: _____) ☐ Separated Social Security Number: _____ Veteran: ☐ Yes ☐ No

Address: _____
Street Address City County State Zip Code

Home Phone: _____ Cell Phone: _____ Email Address: _____

In Skilled Nursing Facility? ☐ Yes ☐ No If **YES**, date of placement: _____

Name of Facility: _____

Address of Facility: _____
Street Address City County State Zip Code

If **NO**: Occupation: _____ ☐ Currently Employed ☐ Retired

CLIENT CARE OF / OTHER POINT(S) OF CONTACT (if applicable)

Client 3 Information: Relationship to Above: _____ Gender: ☐ Male ☐ Female

Legal Name (First, MI, Last): _____ ☐ Sr. ☐ Jr. ☐ I ☐ II ☐ III

Home Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____
Street Address City County State Zip Code

Other contact(s):

Legal Name (First, MI, Last): _____ Phone: _____

Legal Name (First, MI, Last): _____ Phone: _____

Legal Name (First, MI, Last): _____ Phone: _____

PERSONAL DATA (cont.)

AGENT UNDER POWER OF ATTORNEY ** Please bring any POA documents with you to the meeting if applicable*

Legal Name (First, MI, Last): _____ ☐ Sr. ☐ Jr. ☐ I ☐ II ☐ III

Address: _____
Street Address City County State Zip Code

Home Phone: _____ Cell Phone: _____ Email Address: _____

Relationship to Client 1 (and/or 2): _____ **Type of POA:** ☐ FPOA ☐ HPOA ☐ Both

CHILDREN INFORMATION

Do you have any children? ☐ Yes, I have: _____ ☐ No, I do not have any children

Are any of your children receiving SSI or other form of government entitlement? ☐ Yes ☐ No

Are any of your children blind or disabled? ☐ Yes ☐ No

ASSET INFORMATION

MONTHLY INCOME*

	CLIENT 1 MONTHLY INCOME	CLIENT 2 MONTHLY INCOME
Social Security Benefits (*Including Medicare Part B Deduction if applicable*)	$	$
Retirement Benefits (Gross)	$	$
Veterans Disability Income	$	$
Annuity Income	$	$
Rental Income	$	$
Other Income	$	$
TOTAL MONTHLY INCOME	$ 0.00	$ 0.00

** 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*

ASSETS / LIABILITIES

ASSETS	CLIENT 1	CLIENT 2	JOINT	DEBTS	COMPANY / ACCT #
Personal Effects / Household Items	$	$	$	$	
Automobile	$	$	$	$	
Additional Automobile(s)	$	$	$	$	
Checking Account	$	$	$	$	
Savings Account	$	$	$	$	
Money Market Account	$	$	$	$	
Certificates of Deposits	$	$	$	$	
Residence *(Assessed Value from Tax Bill)*	$	$	$	$	
Other Real Estate	$	$	$	$	
Mutual Funds	$	$	$	$	
Stocks	$	$	$	$	
Bonds	$	$	$	$	
Annuities	$	$	$	$	
Retirement Accounts	$	$	$	$	
Cash on Hand	$	$	$	$	

What did you pay for your current home (include any home improvements): _____

Address of any real estate property OTHER than primary residence (*can be obtained from Tax Bill*):

1: _____
Street Address City County State Zip Code

Tax Block # _____ Lot # _____ Owner(s): _____

2: _____
Street Address City County State Zip Code

Tax Block # _____ Lot # _____ Owner(s): _____

Have you sold or transferred any property in the past 60 months? ☐ Yes ☐ No

Have you sold, traded in, or transferred any vehicles in the past 60 months? ☐ Yes ☐ No

Current mileage on all owned vehicles:

Year: _____ Make: _____ Model: _____ Mileage: _____ Owner(s): _____

Year: _____ Make: _____ Model: _____ Mileage: _____ Owner(s): _____

Year: _____ Make: _____ Model: _____ Mileage: _____ Owner(s): _____

YOUR ADVISORS

Accountant: _____ Phone: _____

Financial Advisor: _____ Phone: _____

Life Insurance Advisor: _____ Phone: _____

Other Attorney: _____ Phone: _____

Other Consultant / Advisor: _____ Phone: _____

MONTHLY COST OF NURSING HOME / ASSISTED LIVING FACILITY

Currently living in: ☐ Skilled Nursing Home ☐ Assisted / Independent Living ☐ Home (or with Family Member)

Care is being paid: ☐ Out of Pocket ☐ Medicare ☐ Medicaid

MONTHLY COST OF NURSING HOME

Monthly Nursing Home /ALF Cost	$
Monthly Prescription Cost	$
Monthly Other Cost	$
Total Monthly Cost	$ 0.00

The Nursing Home / ALF is paid through: _____ month / year

MONTHLY SHELTER EXPENSES

Rent/ Mortgage	$
Real Estate Taxes	$
Homeowner's Insurance Premium	$
Condominius / HOA Fees	$
Utilities	$
Total Montly House Expenses	$ 0.00

MONTHLY NON-SHELTER LIVING EXPENSES

Please list any significant monthly non-shelter living expense not disclosed above

_____

_____

_____

*LIFE INSURANCE INFORMATION**

INSURANCE COMPANY NAME: ______________________________

Policy Number: ______________________ Owner: ______________________

Insured: ______________________ **Is there more than one beneficiary?** ☐ Yes ☐ No

Beneficiary(ies): ______________________________

Death Benefit: $____________ Cash/Face Value: $____________ Recipient: ____________

INSURANCE COMPANY NAME: ______________________________

Policy Number: ______________________ Owner: ______________________

Insured: ______________________ **Is there more than one beneficiary?** ☐ Yes ☐ No

Beneficiary(ies): ______________________________

Death Benefit: $____________ Cash/Face Value: $____________ Recipient: ____________

INSURANCE COMPANY NAME: ______________________________

Policy Number: ______________________ Owner: ______________________

Insured: ______________________ **Is there more than one beneficiary?** ☐ Yes ☐ No

Beneficiary(ies): ______________________________

Death Benefit: $____________ Cash/Face Value: $____________ Recipient: ____________

INSURANCE COMPANY NAME: ______________________________

Policy Number: ______________________ Owner: ______________________

Insured: ______________________ **Is there more than one beneficiary?** ☐ Yes ☐ No

Beneficiary(ies): ______________________________

Death Benefit: $____________ Cash/Face Value: $____________ Recipient: ____________

*GIFTING INFORMATION**

Have you made "**gifts**" in excess of $500 in any one month including (but not limited to):

- College Tuition Payments, Monetary Gifts to the Church, and/or Christmas/Birthday gifts to an individual or group of individuals
- Transferred any funds to an individual or group of individuals, within the past 60 months
- Transferred any funds to a Trust within the past 60 months

And/or removed names from any bank, investment or financial accounts jointly held with another individual within the last 60 months?

☐ Yes ☐ No If **YES**, please list below:

Date of Gifting: ____/____/____ Amount: $____________ Recipient: ____________

Date of Gifting: ____/____/____ Amount: $____________ Recipient: ____________

Date of Gifting: ____/____/____ Amount: $____________ Recipient: ____________

Date of Gifting: ____/____/____ Amount: $____________ Recipient: ____________

Date of Gifting: ____/____/____ Amount: $____________ Recipient: ____________

** If either the **Life Insurance Information** or the **Gifting Information** exceeds the allotted amount of spaces, please list on a separate sheet of paper.*

MISCELLANEOUS

Do you have an Irrevocable Burial Account? ☐ Yes ☐ No

Do you have a current Will? (*If yes, please provide a copy or bring original to the next meeting*) ☐ Yes ☐ No

Do you have a Living Will? (*If yes, please provide a copy or bring original to the next meeting*) ☐ Yes ☐ No

Have you ever applied for or received government benefits before? ☐ Yes ☐ No

Are you currently on PACE or any other state pharmaceutical plans? ☐ Yes ☐ No

Do you have a Medigap (supplemental health insurance) policy? ☐ Yes ☐ No

Do you have any other legal issues that we should be aware of? ☐ Yes ☐ No

☐ If **YES**, please explain: _____

_____

HEALTH DATA

Name of ill Client: _____ Gender: ☐ Male ☐ Female
Legal Name (First, MI, Last)

Prognosis: _____ Course of Treatment: _____

Primary Physician: _____ Phone: _____

Name of ill Client: _____ Gender: ☐ Male ☐ Female
Legal Name (First, MI, Last)

Prognosis: _____ Course of Treatment: _____

Primary Physician: _____ Phone: _____

Name of Well Client: _____ Gender: ☐ Male ☐ Female
Legal Name (First, MI, Last)

Current Main Residence: _____

Current Health: _____ Any concerns? _____

Primary Physician: _____ Phone: _____

Anything else you think we should know regarding the health of the client(s)?:

_____

_____

_____

CERTIFICATION

The undersigned hereby represents to Heritage Elder Law & Estate Planning, LLC. 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: _____

Printed Name of Signee Above: _____

HERITAGE ELDER & ESTATE PLANNING, LLC.
LONG-TERM CARE DOCUMENTATION LIST

If you are able, please bring the following documentation to your initial consultation for Long-Term Care Planning. If available, you MUST bring a copy of the current Power of Attorney document.

- Copy of Power of Attorney or guardianship papers
- Social Security card for self and spouse (if living)
- Birth verification - copy of birth certificate for self and spouse (if living)
- Copy of driver's license or other Photo identification
- Naturalization/alien registration if foreign born
- Marriage license or certificate and/or death certificate of spouse
- Military discharge papers for client and/or spouse, (if applicable)
- Previous marriage certificates for either partner and divorce / Annulment / Separation papers (if applicable)
- Medicare card for self and spouse (if living).
- Supplemental Health Insurance Cards
- Health Insurance premium notice for self and spouse
- Nursing Home Bill and Nursing Home Contract (Admissions agreement, responsible party agreement and/or Personal care contract)
- Documentation of all financial accounts held individually and/or jointly. Copies of checking account statements with corresponding checkbook register, savings account, CDS, stocks, bonds, money markets, trusts, annuities, IRA/Retirement accounts etc. for the **previous 2 years and January/July Statements for 3 years prior**
    - Example: If you meet with us on September 1, 2000, we need January and July 1996, January and July 1997, January and July 1998, and September 1, 1998 - September 1, 2000
    - Copies of any checks more than $500 on these statements
- Deed(s), current property tax card(s), and mortgage statement
- Sales agreements of property if sold within the last 5 years. (HUD-1)
- Funeral contracts and/or cemetery lot deed(s)
- Life insurance policies (spouse's if living). Please provide documentation of the face and current cash value of each policy
- Titles or lease agreement to all vehicles and current mileage
- Sales agreement for any vehicles sold in the last 5 years
- Proof of all monthly income (spouse's if living). Please provide copies of award letters [Social Security, VA Benefits] or let us know if it's only shown on bank statements
- Proof of any income you have applied for (VA, SSI, SSD)
- If spouse is living, we need proof of living expenses, including rent or mortgage
    - Payment, utilities and homeowner's or renter's insurance
- Copies of any applications previously submitted to Department of Public Welfare
- Award letters or other correspondence from Department of Public Welfare
- Income Tax returns, including 1099 year end statements for last 5 years

ALL DOCUMENTATION LISTED IS REQUIRED FOR A MEDICAID APPLICATION.
ADDITIONAL DOCUMENTATION MAY BE REQUESTED BASED ON YOUR UNIQUE CASE.