

**MEDICAID PLANNING QUESTIONNAIRE  
(SINGLE)**

Date \_\_\_\_\_ File No. \_\_\_\_\_  
Home Phone No. \_\_\_\_\_ Business Phone No. \_\_\_\_\_  
Cell Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

**This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to your appointment.**

**A. CLIENT DATA**

Full Name \_\_\_\_\_  
(print name as shown on your checks)

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security No. \_\_\_\_\_

U.S. Citizen?     Yes         No                      Veteran?     Yes         No

If widowed, please list name of spouse and date of death \_\_\_\_\_

Was your former spouse a Veteran?     Yes         No

If you or your former spouse is or was a Veteran, are you receiving Tricare?     Yes         No

**B. MEDICAL DATA**

**1. HEALTH**

Diagnosis \_\_\_\_\_

If you are already in a nursing home:

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

Date Entered \_\_\_\_\_

**2. PHYSICIAN**

Full Name of Primary Physician \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**3. PHARMACEUTICAL PLANS**

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior GOLD? G Yes      G No

If you are a Pennsylvania resident, are you currently receiving benefits under PACE? G Yes      G No

If you are a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? G Yes      G No

**C. MONTHLY INCOME**

Net Social Security Benefits \$ \_\_\_\_\_

Medicare Part B Deduction G \$93.50  
G \$106.00  
G \$143.40  
G \$162.10

Co-pay for Medicare Part D (if applicable) \$ \_\_\_\_\_

Retirement Benefits (Gross) \$ \_\_\_\_\_

Veterans Disability Income \$ \_\_\_\_\_

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 any other reason.

**Do not include interest and dividend income on this form.**

**D. GIFTS**

Have you made any gifts within the last five years to an individual or to a trust?     Yes             No

If yes, list below:

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

Recipient \_\_\_\_\_ Date \_\_\_\_\_ Amount \_\_\_\_\_

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

If yes, please state details

---

---

---

**E. CHILDREN (if applicable, include adult and minor children)**

**Name of Child** \_\_\_\_\_ Gender:     Male             Female

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Relationship:     Natural child  Adopted             Stepchild             Child born out of wedlock

**Name of Child** \_\_\_\_\_ Gender:    G Male        G Female  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Relationship:    G Natural child    G Adopted        G Stepchild        G Child born out of wedlock

**Name of Child** \_\_\_\_\_ Gender:    G Male        G Female  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Relationship:    G Natural child    G Adopted        G Stepchild        G Child born out of wedlock

**Name of Child** \_\_\_\_\_ Gender:    G Male        G Female  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_  
Relationship:    G Natural child    G Adopted        G Stepchild        G Child born out of wedlock

Name of Child \_\_\_\_\_ Gender:  Male  Female

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Relationship:  Natural child  Adopted  Stepchild  Child born out of wedlock

Are all of your children in good health?  Yes  No

Are any of your children blind?  Yes  No

Are any of your children disabled?  Yes  No

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

If yes: How much is the child's monthly payment? \$ \_\_\_\_\_

Is the child receiving Medicaid or Medicare?  Medicaid  Medicare

Do any of your family members have any problems with:

AIDS?  Yes  No

Drug Addiction?  Yes  No

Alcoholism?  Yes  No

Spendthrift?  Yes  No

Marital Difficulty?  Yes  No

Do any of your children live with you in your home?  Yes  No

If yes, name of child \_\_\_\_\_

Does a sibling live in your home with you?  Yes  No

If yes, name of sibling \_\_\_\_\_

Are you a contributor to a 529 Plan?  Yes  No

If yes, please attach a statement of the 529 account.

**F. CONTACT INFORMATION**

Name\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone Number\_\_\_\_\_ Work Phone Number\_\_\_\_\_

Cell Number \_\_\_\_\_ Fax Number\_\_\_\_\_

E-mail Address\_\_\_\_\_

**G. MISCELLANEOUS**

Do you have any other legal issues which I should be aware of:     G Yes G No

If yes, please explain

\_\_\_\_\_  
\_\_\_\_\_

**H. REFERRAL**

By Whom Were You Referred To This Office?

Name\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Home Phone Number\_\_\_\_\_ Work Phone Number\_\_\_\_\_

Cell Number \_\_\_\_\_ E-mail Address\_\_\_\_\_

Referral is: G Attorney

G Financial Planner

G Previous Client of Begley & Bookbinder

G Doctor

G Social Worker

G Other\_\_\_\_\_

Have you visited our Website at [www.njelderlaw.com](http://www.njelderlaw.com) or [www.begleylawyer.com](http://www.begleylawyer.com)?     Yes G     No G

Do you have any ideas for improving our Website? If so, please discuss.

---

---

---

---

**H. CERTIFICATION**

The undersigned hereby represents to Begley & Bookbinder, P.C., 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 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:

---

## MEDICAID PLANNING -ADDITIONAL INFORMATION

Last Name of Client \_\_\_\_\_

File No. \_\_\_\_\_

### A. ASSETS/LIABILITIES

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING		
SAVINGS		
MONEY MARKET		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ EQ. RATIO _____ REM. FCTR _____		
OTHER REAL ESTATE BLOCK# _____ LOT# _____ EQ. RATIO _____ REM. FCTR _____		
AUTOMOBILE(S)		
BROKERAGE/CAP ACCOUNTS		

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
TRADITIONAL IRA/RETIREMENT PLANS		
ROTH IRA		
NURSING HOME DEPOSIT		
PREPAID FUNERAL		
OTHER:		
OTHER:		
OTHER:		
<b>TOTAL</b>		

**Residence Information**

Purchase Price \$ \_\_\_\_\_

Purchase Costs  
(title & escrow fees, real estate agent commissions, etc.) + \$ \_\_\_\_\_

Improvements + \$ \_\_\_\_\_

Selling Costs  
(title & escrow fees, real estate agent commissions, etc.) + \$ \_\_\_\_\_

Accumulated Depreciation - \$ \_\_\_\_\_

Cost Basis = \$ \_\_\_\_\_

Have you owned the property for 2 of the last 5 years? G Yes G No

Have you occupied the property for 2 of the last 5 years? G Yes G No

Have you sold property within the last 2 years? G Yes G No

If yes:

What was the cost basis of the property? \$ \_\_\_\_\_

What was the sales price? \$ \_\_\_\_\_

Have you gifted property? G Yes G No

If yes:

Number of Donees \_\_\_\_\_

Amount of Credit Available \_\_\_\_\_

**Other Real Property Information**

Address of any real property 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? \$ \_\_\_\_\_

Name of Homeowner's Insurance Company \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Policy No. \_\_\_\_\_

**B. MONTHLY COST OF NURSING HOME**

Monthly Nursing Home Cost \$ \_\_\_\_\_

Monthly Prescription Cost \$ \_\_\_\_\_

Monthly Incontinent Cost \$ \_\_\_\_\_

Monthly Medical Insurance Cost \$ \_\_\_\_\_

Monthly Other Cost \$ \_\_\_\_\_

**Total Monthly Cost** \$ \_\_\_\_\_

The nursing home is paid through \_\_\_\_\_ (month/year).

**C. LIFE INSURANCE**

**Name of Insurance Company** \_\_\_\_\_ **Policy #** \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_

Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_

Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

**Name of Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_  
Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_  
Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

**Name of Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_  
Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_  
Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

**Name of Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_  
Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_  
Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_

**Name of Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Type of Policy \_\_\_\_\_ Owner \_\_\_\_\_  
Insured \_\_\_\_\_ Beneficiary \_\_\_\_\_  
Death Benefit: \$ \_\_\_\_\_ Face Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_