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PRACTICING EXCLUSIVELY IN:
ELDER LAW
ASSET PROTECTION
MEDICAID & NURSING HOME PLANNING
ESTATE PLANNING
DISABILITY PLANNING
MEDICAID APPLICATIONS
GUARDIANSHIP
WILLS & TRUSTS
ESTATE ADMINISTRATION

MEDICAID PLANNING

Dear Client:

Attached is our Medicaid Planning questionnaire. Elder Law Associates, P.A. recognizes that the information requested in this questionnaire is highly personal. Please be assured that all information provided shall be kept confidential in accordance with the attorney/client privilege as required by the Rules Regulating The Florida Bar, Chapter 4. Rules of Professional Conduct.

The purpose of this questionnaire is to gain as much information in advance to minimize time delays and to maximize the advice we may give you during our initial consultation. We want this to be a very productive meeting.

All we ask is that you do your best in completing this questionnaire. We are happy to work with you to fill in any ‘gaps’ as needed.

ADDITIONAL OFFICES:
AVENTURA: 20801 Biscayne Blvd., Suite 304, Aventura, FL 33180 ▪ (305) 682-8330
WEST PALM BEACH: 777 S. Flagler Dr., Suite 800, West Palm Beach, FL 33401 ▪ (561) 805-9533
WESTON: 2843 Executive Park Dr., Weston, FL 33331 ▪ (954) 726-1214

ASSET PROTECTION & MEDICAID PLANNING QUESTIONNAIRE

THIS INFORMATION IS EXTREMELY IMPORTANT TO ENABLE US TO SERVE YOU.
IF ASSISTANCE IS NEEDED TO COMPLETE THE FORM, PLEASE CALL US.

Throughout this Questionnaire, please use the back of each page
to write additional information.

Date ________________________________

Referred to Ellen Morris, Esq. or Howard S. Krooks, Esq. by:________________________________

PERSONAL DATA of the Person Who Will Receive Medicaid Benefits: "Applicant"

Name:________________________________
Home Address:

____

____

Telephone: ________________________________

E-Mail address: ________________________________

Facility Name, Address & Telephone:

____

____

____

Social Services Person:________________________

Date of Admission:________________________

Dates of Medicare coverage:________________

Birth Date:________________________________

Place of Birth:________________________________
(Bring Birth Certificate and Drivers License)

Social Security Number:____________________
(Bring Social Security AND Medicare Card)

PERSONAL DATA of the Spouse:

Spouse Name:________________________________
Home Address:

____

____

How long at this address:
Telephone:________________________________

Telephone (cell):________________________________

E-Mail address: ________________________________

Birth Date:________________________________

Social Security No.____________________________
(Bring Social Security AND Medicare Card)

Community Spouse resides in:

( ) Rental home/apartment

( ) Own home/apartment

( ) Nursing Home/Care Facility

Name of Facility________________________________

FAMILY MEMBERS AND OTHERS INTERESTED IN YOUR WELFARE

NAME ______________________________ **Date of Birth:** ______________

—

Address ____

Relationship __________ **Telephone home:** __________ **work:** __________ **cell:** __________

Spouse's Name ________________ **E-Mail address:** ______________________

NAME ______________________________ **Date of Birth:** ______________

Address ____

Relationship __________ **Telephone home:** __________ **work:** __________ **cell:** __________

Spouse's Name ________________ **E-Mail address:** ______________________

NAME ______________________________ **Date of Birth:** ______________

Address ____

Relationship __________ **Telephone home:** __________ **work:** __________ **cell:** __________

Spouse's Name ________________ **E-Mail address:** ______________________

NAME ______________________________ **Date of Birth:** ______________

Address ____

Relationship __________ **Telephone home:** __________ **work:** __________ **cell:** __________

Spouse's Name ________________ **E-Mail address:** ______________________

IMPORTANT
Are any of your children on Social Security Disability: ______________________________
(Name child)

CURRENT LEGAL DOCUMENTS	YES	NO
LAST WILL AND TESTAMENT		
REVOCABLE TRUST		
DURABLE POWER OF ATTORNEY		
HEALTH CARE SURROGATE		
LIVING WILL		

Primary Physician Name, Address & Telephone:

____

Is your physician a BOARD CERTIFIED GERIATRIC PHYSICIAN? ____YES ____ NO ____ UNKNOWN

Stock Broker Name & Address & Phone: ____

Accountant or CPA Name & Address & Phone:____

Safe Deposit Box: Name of Bank & Branch & Box #_____________________________________

Who is authorized to enter box? ____

Has Applicant or Spouse ever been in or worked for the following: (Complete this even if Spouse is deceased)

Military Service	_____ **Yes** ______ **No**	**Private Employer Pension Plan** _______ **Yes** ______ **No**
Federal Government	______**Yes** ______ **No**	**Trade Union with Pension Plan** _______ **Yes** _______ **No**
State Government	______ **Yes** ______ **No**	**Railroad Retirement** _______ **Yes** ______ **No**

If Applicant served in military: What Branch?:____

Have you applied for VA BENEFITS (Aid and Attendance)? ______ YES _______ NO

If yes, when did you apply for benefits?____

When did you start receiving benefits?____

If SPOUSE has served in military: What Branch?____

Have you applied for VA BENEFITS (Aid and Attendance)? _______ YES ______ NO

If yes, when did they apply for benefits? ____

When did they start receiving benefits? ____

MONTHLY INCOME SUMMARY

LIST ALL INCOME THAT APPLICANT OR SPOUSE RECEIVE IN MONTHLY AMOUNTS:

SOURCE	APPLICANT	SPOUSE
SOCIAL SECURITY (GROSS AMOUNT)		
PENSION #1 (GROSS AMOUNT)		
SOURCE OF PENSION		
PENSION #2 (GROSS AMOUNT)		
SOURCE OF PENSION		
CIVIL SERVICE PENSION		
VETERANS BENEFITS		
RAILROAD RETIREMENT INCOME		
INTEREST INCOME		
DIVIDEND INCOME		
ALIMONY		
ANNUITY PAYMENTS		
IRA PAYMENTS		
RENTAL INCOME		
CURRENT WAGES		

ASSET SUMMARY

PLEASE COMPLETE THE FOLLOWING CHART WITH THE TOTAL ASSETS IN EACH CATEGORY. PLEASE ALSO PROVIDE THE LAST THREE STATEMENTS FOR EACH ACCOUNT OR ASSET.

ASSET TYPE	APPLICANT-BALANCE	SPOUSE -BALANCE	JOINT-BALANCE
BANK NAME & ACCOUNT #s			
CD BANK NAME & ACCOUNT #s			
STOCK NAMES & ACCOUNT #s			
CORPORATE BONDS & ACCOUNT #s			
MUNICIPAL BONDS & ACCOUNT #s			

US SAVINGS BONDS & ACCOUNT #s			
MUTUAL FUNDS & ACCOUNT #s			
LIMITED PARTNERSHIPS & ACCOUNT #s			
GNMA & ACCOUNT #s			
ANNUITIES & ACCOUNT #s			
IRA ACCOUNTS & ACCOUNT #s			

PROPERTY

Any GIFTS for over $1,000 in value within the past **60** months? If YES, explain in full detail.
Have you purchased an Annuity since February 2006? Please list Annuity.

____

____

____

____

Here list all real property owned by Applicant, Spouse or Applicant and Spouse jointly.

BRING LAST REAL ESTATE TAX BILL FOR EACH PROPERTY

HOMESTEAD (YOUR PROPERTY) Address: ____

Is this residence a: __________ house ___________ mobile home ___________ condominium

______ other (describe) ____

Names on the Deed: ____

What is the balance due on your mortgage? $____

If you were going to sell your home, what price would you expect to receive $_______________________

ALL OTHER REAL ESTATE:

PROPERTY A: ADDRESS: ____

Names on the Deed: ____

What is the present value of the property: $ ____

How much is presently owed on a mortgage on this property? $ ______________________________

Do you receive rental income? ______ Yes ______ No Monthly Rental Amount $__________________

If there is a written lease, attach copy of LEASE

If other parcels are owned, provide same information on extra page.

BURIAL ASSETS

1. **Do you own cemetery plots?** ___________ Applicant ___________ Spouse

   IF YES, ATTACH COPY OF DEED.

2. List any burial contracts or pre-paid funeral agreements applicant/spouse has purchased (please provide copy of each agreement or contract)

   APPLICANT: ______________________________________ Date of purchase:______________

   Name of Funeral Home: ____

   Name of Insurance Co: ____

   Is contract IRREVOCABLE: ______________ Amount $: ________________________________

   SPOUSE: ______________________________________ Date of purchase:______________

   Name of Funeral Home: ____

   Name of Insurance Co: ____

   Is contract IRREVOCABLE: ______________ Amount $: ________________________________

Does Applicant/Spouse have a special bank account set aside for burial funds?

________ YES __________ NO

LOANS (MORTGAGES AND NOTES, MONEY DUE TO YOU)

Does Applicant or Spouse OWN a mortgage and/or a promissory note? _______ YES _______ NO

LOAN #1: Names on the note or mortgage:

____

Principal balance remaining due $____

Is the mortgage marketable (can it be sold?) __________ YES _________ NO

If marketable, what could you sell it for? $____

IS APPLICANT OR SPOUSE THE BENEFICIARY OF ANY TRUSTS (indicate value, assets, distributions available or expected)

Applicant: ____

Spouse: ____

EXPECTED INHERITANCES

Applicant: ____

Spouse: ____

APPLICANT'S INSURANCE

LIFE INSURANCE: (Includes life insurance held by funeral home for burial)

Complete the following AND BRING COPIES OF POLICIES FOR THE FILE.

Company/ Policy #	Owner	Insured	Face Value	Cash Value	Loans

SPOUSE'S INSURANCE

LIFE INSURANCE: (Includes life insurance held by funeral home for burial)

Complete the following AND BRING COPIES OF POLICIES FOR THE FILE.

Company/ Policy #	Owner	Insured	Face Value	Cash Value	Loans

LONG TERM CARE POLICIES:

Does Applicant or Spouse have any long term care policies? _______YES _______ NO

If YES, BRING COPIES OF POLICY AND CURRENT PREMIUM STATEMENT.

HEALTH/MEDICAL INSURANCE:

Does Applicant or Spouse have health or medical insurance? ________YES _______ NO

If YES, BRING COPIES OF INSURANCE POLICY, CARD, AND CURRENT PREMIUM STATEMENT.

List Insured, Policy # and Name and Address of Insurance Company:

APPLICANT: ____

SPOUSE: ____

HOW IS PREMIUM PAID: ____

PORTION OF PREMIUM ATTRIBUTABLE TO APPLICANT: ______________________________

PORTION OF PREMIUM ATTRIBUTABLE TO SPOUSE: ______________________________

MOTOR VEHICLES

Does Applicant or Spouse own a vehicle? _______ YES ________ NO

PLEASE BRING COPY OF VEHICLE TITLE

Make/Model/Year **Value Owner Name**

_____________________ ____

____

_____________________ ____

____

Does Applicant have current driver's license? ______YES ______ NO

Does Spouse have current driver's license? ______YES ______ NO

If YES, we must submit photocopies of driver's licenses to DCF along with Name of Insurance Company, Proof of Insurance.

PLEASE BRING MOST RECENT BILLING for proof of premium.