

**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 \_\_\_\_\_

**C. MONTHLY INCOME**

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

Medicare Part B Deduction \$ \_\_\_\_\_

Co-pay Medicare Part D \$ \_\_\_\_\_

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

Employment \$ \_\_\_\_\_

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

Annuity Income \$ \_\_\_\_\_

Rental Income \$ \_\_\_\_\_

Other \_\_\_\_\_ \$ \_\_\_\_\_

**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 1** \_\_\_\_\_ 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 2** \_\_\_\_\_ 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 3** \_\_\_\_\_ 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 4** \_\_\_\_\_ 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 5 \_\_\_\_\_ 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?  Medicare  Medicaid

Do any of your family members have any problems with:

AIDS?  Yes  No

Drug Addiction?  Yes  No

Alcoholism?  Yes  No

Spendthrift?  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. GRANDCHILDREN**

Name of Grandchild 1 \_\_\_\_\_ Gender:  Male  Female

Relationship:  Natural grandchild  Stepgrandchild

Name of Grandchild 2 \_\_\_\_\_ Gender:  Male  Female

Relationship:  Natural grandchild  Stepgrandchild

Name of Grandchild 3 \_\_\_\_\_ Gender:  Male  Female

Relationship:  Natural grandchild  Stepgrandchild

Name of Grandchild 4 \_\_\_\_\_ Gender:  Male  Female

Relationship:  Natural grandchild  Stepgrandchild

Name of Grandchild 5 \_\_\_\_\_ Gender:  Male  Female

Relationship:  Natural grandchild  Stepgrandchild

Are all of your grandchildren in good health?  Yes  No

Are any of your grandchildren disabled?  Yes  No

**G. CONTACT INFORMATION**

Name \_\_\_\_\_

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

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

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

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

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

**H. MISCELLANEOUS**

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

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**I. 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:  Attorney  Financial Planner  
 Previous Client of Law Firm  Doctor  
 Social Worker  Other \_\_\_\_\_

**J. CERTIFICATION**

The undersigned hereby represents to The Grodberg Law Firm 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)<br>BLOCK# _____ LOT# _____<br>EQ. RATIO _____ REM. FCTR _____ |             |                 |
| OTHER REAL ESTATE<br>BLOCK# _____ LOT# _____<br>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/CREMATION        |             |                 |
| 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?  Yes  No

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

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

If yes:

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

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

Have you gifted property?  Yes  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 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: \$ \_\_\_\_\_