THE LAW OFFICES OF
JONATHAN S. FRANK, PC
ESTATE PLANNING ■ ELDER LAW ■ ASSET PROTECTION

MEDICAID PLANNING QUESTIONNAIRE

Date: _____

Client or Client's Representative(Individual Completing this Questionnaire):

_____

Home Phone No.: _____Work or Cell Phone No._____ Email: _____

A. PERSONAL DATA

Full Name (Person #1) _____

Street Address_____

City_____ State_____ Zip_____

Birth Date _____

Social Security No. _____

U. S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

SPOUSE (if any)

Full Name (Person # 2) _____

Street Address_____

City_____State_____Zip_____

Birth Date_____

Social Security No._____

U.S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐

B. MEDICAL DATA FOR PERSON #1

Diagnosis _____

Prognosis _____

Course of Treatment _____

Where Individual Currently Resides _____
_____

If individual has already entered a nursing home, please indicate the name of the nursing home and the first date entered on a continuous basis _____

MEDICAL DATA FOR PERSON #2

Diagnosis _____

Prognosis _____

Course of Treatment _____

Where Individual Currently Resides _____
_____

If individual has already entered a nursing home, please indicate the name of the nursing home and the first date entered on a continuous basis _____

C. MONTHLY INCOME

	Person # 1 Monthly Income	Person #2 Monthly Income
Social Security Benefit (Gross)	$_____	$_____
Retirement Benefit (Gross)	$_____	$_____
VA Disability Benefit	$_____	$_____
Annuity Income	$_____	$_____
Interest Income	$_____	$_____
Rental Income	$_____	$_____
Dividend Income	$_____	$_____
Total Monthly Income	$_____	$_____

Please list the gross social security amount and/or pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

D. MONTHLY COST OF NURSING HOME FOR PERSON # 1

$_____ Monthly Nursing Home Cost

$_____ Monthly Incidental Cost

$_____ Monthly Prescription Cost

$_____ Monthly Other Cost

$_____ **Total Monthly Costs**

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

MONTHLY COST OF NURSING HOME FOR PERSON # 2

$_____ Monthly Nursing Home Cost

$_____ Monthly Incidental Cost

$_____ Monthly Prescription Cost

$_____ Monthly Other Cost

$_____ **Total Monthly Costs**

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

E. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12, and quarterly expenses by 3.)

$_____ Rent/Mortgage

$_____ Real Estate Taxes

$_____ Water

$_____ Sewer

$_____ Utilities (Heat, Electric)
(1/12 of last 12 months)

$_____ Homeowner's insurance premium

$_____ Condominium fees

$_____ **Total Monthly Housing Expenses**

F. MONTHLY NON-SHELTER EXPENSES

(Please estimate)

$_____	Food
$_____	Medical
$_____	Clothing
$_____	Telephone
$_____	Transportation (including auto insurance)
$_____	Home Maintenance
$_____	Life Insurance Premiums
$_____	Health Insurance Premiums
$_____	Medicare Supplemental Insurance Premiums
$_____	Cable TV
$_____	Federal and State Income Taxes
$_____	Other
$_____	**Total Monthly Non-Shelter Living Expenses**

G. ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Value	Liability
AUTOMOBILE		
ADDITIONAL AUTOMOBILE		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICIATES OF DEPOSIT		
RESIDENCE		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
IRA		
OTHER REAL ESTATE		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
TOTALS		

H. LIFE INSURANCE

COMPANY NAME (include address and policy #)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY
COMPANY NAME (include address and policy #)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

I. GIFTS

Please list gifts made in excess of $100 in any one month, to an individual or group of individuals, within the past 60 months (Use separate page if necessary):

Recipient _____ Date_____ Amount_____

Recipient _____ Date_____ Amount_____

Recipient _____ Date_____ Amount_____

Recipient _____ Date_____ Amount_____

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

J. CHILDREN (if applicable)

CHILD'S NAME	ADDRESS (With Zip Code)	TELEPHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Are all of your children in good health? Yes ☐ No ☐
If answer is no, who? _____
Are any of your children receiving SSI or other forms of government entitlement? Yes ☐ No ☐
If answer is yes ,who? _____
Do any of your children live with you in your home? Yes ☐ No ☐
If answer is yes ,who? _____

K. CERTIFICATION

The undersigned hereby represents to The Law Firm of Jonathan S. Frank, PC that the information contained in this intake form is accurate and complete, and that the undersigned understands that The Law Firm of Jonathan S. Frank, PC will rely on this information for purposes of developing a Medicaid plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Medicaid eligibility.

Dated: _____

Signature of Client or Client Representative:

_____

Confidentiality Notice: E-mail or facsimile transmission is not a secure form of communication; therefore, e-mail or fax transmission cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. The sender therefore accepts liability for any errors or omissions in the contents of the message, which arise as a result of e-mail or fax transmission.