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ESTATE PLANNING QUESTIONNAIRE
MEDICAL ASSISTANCE

Part A
Personal Information

NAME(S): SINGLE PERSON OR HUSBAND:_____
WIFE:_____
ADDRESS: _____
DATE COMPLETED: _____
PHONE(Daytime): _____ (Evening): _____
E MAIL_____

Single person or Husband:
Date of Birth:_____
Age:_____
Are you a U.S. Citizen?_____
Marital Status: _____
Social Security No:_____
Are you a Veteran? _____

Wife:
Date of Birth:_____
Age: _____
Are you a U.S. Citizen? _____
Marital Status: _____
Social Security No:_____
Are you a Veteran? _____
Maiden Name: _____

Is this a first and only marriage for both of you? _____ Yes _____ No
If not, provide the following:

1) Names of prior spouse(s)_____
   _____
2) How and when prior marriage(s) ended_____
   _____
3) Any children from the prior marriage(s)?_____
   _____
4) Whether you have assets which either of you consider your separate, individual, or not marital property_____
   _____

Your Children

Name and SS #	DOB	Address and Phone #
_____	_____	_____
_____		_____
_____	_____	_____
_____		_____
_____	_____	_____
_____		_____
_____	_____	_____
_____		_____
_____	_____	_____
_____		_____

Are you or your spouse blind? Yes____ No____
If so, who, and since when_____
Are you or your spouse Disabled? Yes_____ No_____
If so, who, and since when_____
Are any of your children blind? Yes___ No___ Who_____

Are any of your children Disabled? Yes___ No___ Who_____

Do any of your children live with you in your home? Yes___ No___
If so, who and since when_____

Are your or your spouse receiving Medicare Part A or B? Yes___ No ___

Part B
Miscellaneous Information

If either or both are in a nursing home or are concerned about entering a nursing home, please list the following:

	HUSBAND	WIFE
Diagnosis:	_____	_____
Prognosis:	_____	_____
Course of Treatment:	_____	_____

If you are already in a nursing home or hospital or assisted living, please indicated the name of the nursing home and the date first entered on a continuous basis: Husband: _____
Wife:_____

Part C
Monthly Income

	HUSBAND	WIFE
Net Salary of Wages	$_____	_____
Social Security Benefits	$_____	_____
Retirement Benefits	$_____	_____
Interest	$_____	_____
Dividends	$_____	_____
Other	$_____	_____
TOTAL INCOME	$_____	_____

If there is a pension, please list the gross pension amount and the name of the company or governmental entity paying the pension. $_____

_____

Do either of you have Long Term Care Insurance? _____ Yes _____ No
If so, provide:

1) The names of the company(s)_____
   _____
2) The amount payable $_____
3) The elimination period _____
4) Does this insurance pay for Assisted Living Facilities? _____
5) Does the insurance provide for in home care? _____

Do either of you qualify for Veteran's Benefits?_____
If so, how much? _____

Are either of you disabled, in full or part, as a result of a service related injury?

_____

Part D
Gifts

Gifts made to an individual other than your spouse within the past 60 months. Attach a separate sheet if needed.

Recipient_____ Date:_____ $_____

Recipient_____ Date:_____ $_____

Recipient_____ Date:_____ $_____

Recipient_____ Date:_____ $_____

Recipient_____ Date:_____ $_____

Part E
Assets

Please insert the approximate value of each asset/liability in the appropriate space. Provide a recent statement for each account.

ASSET	OWNED BY WHOM	FAIR MARKET VALUE	LIABILITIES	BENEFICIARY DESIGNATION
Personal Effects				
Automobile(s)				
Business Interests				
Checking Account				
Savings Account				
Money Market Account				
Savings Certificate				
Residence				
Other Real Estate				
Mutual Funds				
Stocks				
Bonds				
Annuities				
Cash Value of Life Insurance				

ASSET	OWNED BY WHOM	FAIR MARKET VALUE	LIABILITIES	BENEFICIARY DESIGNATION
IRA				
Other				
Other				
Other				
Other				
Other				
TOTALS				

Address of any real property other than personal residence:
For each, please provide copy of tax bill and copy of deed or abstract.

1. Street:_____
   City:_____ State:_____ Zip:_____

2. Street:_____
   City:_____ State:_____ Zip:_____

3. Street:_____
   City:_____ State:_____ Zip:_____

What is your cost basis for your personal residence?_____

Part F
Monthly Housing Expenses
and Non-Shelter Living Expenses

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

Monthly Housing Expenses		**Monthly Non-Shelter Living Expenses**	
Mortgage		Food	
Rent		Medical	
Taxes		Clothing	
Water		Transportation	
Sewer		Home Maintenance	
Utilities (heat & electrical 1/12 of last 12 months)		Life Insurance Premiums	
Homeowner's Insurance		Cable TV	
Condominium Fees		Other	
Monthly Total		**Monthly Total**	

Do you or your spouse have Medical Insurance or Supplement? Yes ___ No___

If yes, please provide the following:

Name of Insurance provider _____

Name of person insured _____

Policy Number and Date coverage began_____

Premium amount (monthly) _____

Do you or your spouse have Medicare D for prescriptions? Provide Details

_____

Part G
Life Insurance

Company Type	Face Value	Cash Value	Insured	Owner	Beneficiary

It is very important to know the cash value of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or all the insurance company directly. (Include the cash value of the life insurance on the Life Insurance Line in Part E). Please provide summary pages which are readily available from the insurance company or your agent.

Part H
Monthly Costs of Nursing Home

Cost Per Month $_____

Prescription Cost Per Month $_____

Incontinent Cost Per Month $_____

Other Per Month $_____

TOTAL MONTHLY COSTS $_____

Part I
Present Estate Plan
(Please bring your present Estate Planning Documents with you).

Do both of you have a Will? _____Yes _____No Please provide copies

Do both of you have a Trust? _____Yes _____No Please provide copies

Do both of you have a Financial Power of Attorney? _____ Please provide copies

If yes, does it expressly permit making gifts? _____ Any limits?_____

Do both of you you have a Health Care Power of Attorney? _____ Please provide copies

Do both of you have a Living Will? _____ Please provide copies

Do both of you have a Marital Property Agreement? _____ Please provide copies

Required Paperwork for Medical Assistance Application

For both Applicant and Spouse (if any)

Personal Info:

- ❑ Birth Certificates
- ❑ Social Security Cards
- ❑ Medicare Cards
- ❑ Health Insurance Cards (& recent statement of premiums both primary and supplemental)
- ❑ Marriage License
- ❑ Proof of Military Service (Discharge Notice)
- ❑ Copies of Powers of Attorney

Income: (All verifications must be for current year)

- ❑ Statement from Social Security
- ❑ Pension Statement
- ❑ Veterans Statement
- ❑ Proof of any and all other income

Assets: for all relevant months;

1. Date of 1st admission to hospital or nursing home
2. Date of first requested eligibility
3. End of each month after up to date of filing

- ❑ Statement for all bank accounts for dates listed above
- ❑ Statement for all stocks, annuities, IRAs etc for dates listed above
- ❑ Statement for all life insurance policies for dates above
- ❑ Deed to house and most recent year's tax bill
- ❑ Vehicle Title
- ❑ Burial Contracts (need copy of actual contracts)

Divestments:

- ❑ List of any gifting in the last five years

Shelter:

- ❑ Copies of current bills for shelter expenses; water/sewer, garbage, electricity, home insurance etc. (This is required only where there is one spouse still living at home, or if we are asking for funds to continue paying expenses of a home)