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MEDICAID PLANNING INFORMATION

Please send in this completed information sheet to our office BEFORE your appointment.

Fully completing this information sheet as accurately as possible will assist us in determining your situation in order to advise you. To make sure you get all your questions answered, **make a list of any questions as you think of them and bring the list to your appointment**. Thank you for calling our office

Appointment date, time: _________________.
Who is likely to receive Medicaid in the future? Husband _____ Wife _____ Both ______

	Husband	Wife
Full Legal Name		
Nickname		
Social Security Number		
Birth date		
Birthplace		
Date of Marriage	Place of marriage:	
All Phone Numbers		
Address		
Lives in a medical care facility? If so, Give name, address, phone. **Give date went into facility**.	Yes____ No____	Yes____ No____
Name, phone number of physician:		
Either have a disability? describe	Yes____ No____	Yes____ No____
Either need medical assistance at home? Describe.	Yes____ No____	Yes____ No____
Live with relative who provides medical care?	Yes____ No____	Yes____ No____
Receives or has applied for Social Security? Describe	Yes____ No____	Yes____ No____
Receives or has applied for Medicare?	Yes____ No____	Yes____ No____
Previously applied for Medicaid? Date?	Yes____ No____ Date______________________	Yes____ No____ Date______________________
Have you ever been turned down for Medicaid? Give details	Yes____ No____	
Persons most likely to help with the Medicaid Application	Name: Address: Phone:	
	Name: Address: Phone:	
List anyone in your household who currently has health insurance? Give name of company, policy number and start date:	Yes____ No____	

List anyone in your household who had health insurance end in the last 6 months		
Do you have access to any health insurance not listed above?	Yes____ No____	Yes____ No____

CHILDREN:

		Only Husband's	Only Wife's	Both
1. Child's Name				
Spouse's name				
Address				
All Phone numbers				

		Only Husband's	Only Wife's	Both
2. Child's Name				
Spouse's name				
Address				
Phone numbers				

		Only Husband's	Only Wife's	Both
3. Child's Name				
Spouse's name				
Address				
Phone numbers				

		Only Husband's	Only Wife's	Both
4. Child's Name				
Spouse's name				
Address				
Phone numbers				

LEVEL OF CARE:

	Husband	Wife
Has a nursing home level of care been established?	Yes____ No____	Yes____ No____
What is the level of care?		
When was the level of care established?		

Check the box that most applies for each activity:

Activities of daily living for **Husband**			
Activity	Needs no help	Needs some help	Unable to do at all
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using the toilet			
Grooming			
Taking medication			
Are you getting assistance with the above activities? Yes____ No____ If yes, please describe:			

Activities of daily living for **Wife**			
Activity	Needs no help	Needs some help	Unable to do at all
Bathing			
Dressing			
Transferring from bed to chair			
Walking			
Feeding self			
Using the toilet			
Grooming			
Taking medication			
Are you getting assistance with the above activities? Yes____ No____ If yes, please describe:			

IMPORTANT INFORMATION WE NEED TO HAVE:

Do you own a home? Yes _____No _____**Bring copy of deed**.

Who is living in the home? Husband ______Wife______ Both _____ Neither _________

Fair market value: _____________________ Mortgage amount: ____________________

Are any minor or disabled children living in the home? Yes____ No____

Do you have a Trust? Yes____ No____ **Bring copy**

Is your home in the name of the Trust? Yes____ No____

Do you have a Marriage Settlement Agreement? Yes____ No____ **Bring copy.**

Do you have a Devolution or Community Property Agreement? Yes __No ___ **Bring copy.**

Do you have a Power of Attorney? Yes___ No____ **Bring copy**

Do you have a funeral burial policy? Yes___ No____If yes, who with? ______________________________

ALL items listed on the Medicaid Application MUST HAVE documents to back up your statements, like currently monthly statements, and we will need this documentation BEFORE we can submit you application to Medicaid.

INCOME:

The Medicaid Application requires the following information. Please list ALL money received or expected by ALL household members. Medicaid requires that you verify this information and sign the application under penalty of perjury regarding these amounts. *Put NA if not applicable*.

Type of money received	Who earned, received money	Name of employer	How often paid	Total monthly amount (gross)
Wages				
Self employed? Name of business years in business				
Social Security (gross per month)	husband			
Social Security (gross per month)	wife			
Gifts or Loans of Cash				
Tips				
Unemployment				
Child support				
Pension (gross per month)	husband			
Pension (gross per month)	wife			
Veteran’s benefits				
Interest Income				
Interest Income				
Interest Income				

IRA distributions	husband			
IRA distributions	wife			
401K				
403B				
Annuities				
Annuities				
Other, give details				
Other				

Does any one in your household have CASH in hand? Yes _____ No_____ How much? ____________

List gross income before taxes received by your household for the last three months.
Last month _______________, two months ago _________________ three months ago _______________

Do you have Medical Insurance? Yes____ No_____

Type of Insurance	Husband	Wife	Premium Amount
Traditional Medicare (physician and hospital - Part A and B?			
Medicare Supplement?			
Medicare Advantage Replacement Plan?			
Medicare Prescription (Part D)			
Employer Retiree Health Plan?			
Private Health Insurance?			
Long Term Care Insurance Contract? Please bring a copy			
Other Type (cancer, accidental, hospital supplement)?			

Do you have Life Insurance and/or Annuities? Yes_____ No______ (please bring in policies)

Name of Insured	Insurance Company	Policy Number	Face Value	Cash Surrender Value, if any

DEBTS

Do you owe money to anyone? (Loans, notes, mortgages, loans from children) Yes ____ No ____

Creditor's name	Date incurred	What was it for?	Total amount owed

Do you owe money for credit cards, medical bills, etc. Yes ____ No ____

Creditor's name	Date incurred	What was it for?	Total amount owed

Any other known debts? Yes____ No______ List on a separate sheet of paper if necessary.

ASSETS

This portion must be completed in full before we can prepare the Resource Assessment. Medicaid requires you to sign that all the information is true and correct under penalty of perjury.

NA if "not applicable, B for "both", W for "wife", H for "husband"

Item	Description				Current Market Value	Amount owed, if any	Who owns?			
	Make	Model	Type	Year			NA	B	W	H
Car										
Car										
Truck, pickup										
Motor home, recreation vehicle										
Boat, trailer, boat motor										
Snowmobile										
Camper, shell										
Utility or livestock trailer										
Van										
Motorcycle										
Airplane										
Other										

Real Estate or related items that you own OR are planning to buy.
Do not list the home in which you live.

Item	Current Market or Face Value	Amount owed	Location or address	Who owns?			
				NA	B	W	H
House							
House							
Land							
Land							
Mobile home							
Land contract							
Mortgage							
Other							

Do you own any of the following?

Item	Current Market or Face Value	Amount owed	Location or address	Who owns?			
				NA	B	W	H
Bank Accts: Checking, Savings; CDs, Money Mkts.							
Indian lands							
Oil, gas, timber or mineral rights							
Mining claim							
Precious metals: gold, silver, etc.							
Farm equipment, livestock							
Gun collection							
Coin collection							
Oriental rugs							
Fine art							
Antiques							
Life estate							
Burial plots							
Inheritance							
Damage claim or insurance settlement							
Other							

GIFTING

Have you gifted or transferred anything in the last five (5) years, other than ordinary Christmas and birthday gifts? This includes money, property, or anything transferred for less than fair market value, and this includes charitable contributions. Yes____ No____

If yes, complete the following:

Recipient		Recipient	
Month/Year		Month/Year	
Item		Item	
Value		Value	

Recipient		Recipient	
Month/Year		Month/Year	
Item		Item	
Value		Value	

Recipient		Recipient	
Month/Year		Month/Year	
Item		Item	
Value		Value	

CHILD CARING FOR PARENT

Has a child of yours been caring for the Medicaid Applicant for at least two years? Yes_____ No_____

Would the applicant have needed to go into a care facility or had to have in-home care if that care was not provided? Yes_____ No_____

Name of child providing care:____

Has that child had any additional employment during this time period? (If so, list dates, place and hours)

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____

____

If yes, then please list the dates care was given, the services provided, and the hours worked per day.
If the type and amount of care changed during this time, give dates and details of care, the hours worked for each time period. Be very specific. Use extra pages if necessary.

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