

# **MEDICAID WORKSHEET #3**

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*Conrad Trosch & Kemmy, P.A.*

**Date** \_\_\_\_\_ **Contact Name:** \_\_\_\_\_

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. Please bring this information with you to your appointment.**

**CLIENT DATA**

**A.**

**(Husband)** \_\_\_\_\_ **(Wife)** \_\_\_\_\_  
Full Name \_\_\_\_\_ Full Name \_\_\_\_\_

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

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

**(Husband)** \_\_\_\_\_ **(Wife)** \_\_\_\_\_  
Birth Date \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

U.S. Citizen?  Yes  No U.S. Citizen?  Yes  No

Veteran?  Yes  No Veteran?  Yes  No

If you or your spouse is a Veteran, are you receiving Tricare?  Yes  No

**B. MEDICAL DATA**

**1. HEALTH**

Name of Ill Spouse \_\_\_\_\_

Diagnosis \_\_\_\_\_

If Ill Spouse has already entered a nursing home:

Name of Nursing Home \_\_\_\_\_

Date Entered \_\_\_\_\_

Name of Well Spouse \_\_\_\_\_

Where Well Spouse Currently Resides \_\_\_\_\_

\_\_\_\_\_

**2. PHYSICIAN**

Full Name of Husband's Primary Physician \_\_\_\_\_

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

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

Full Name of Wife's Primary Physician \_\_\_\_\_

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

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

**C. ASSETS**

[Complete Attached Schedule of Assets/Liabilities.]

**D. MONTHLY INCOME**

	Husband's Monthly Income	Wife's Monthly Income
Net Social Security Benefits	\$ _____	\$ _____
Employment Income (if applicable)	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Other Income	\$ _____	\$ _____
<b>TOTAL MONTHLY INCOME</b>	\$ _____	\$ _____

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.**

**E. MONTHLY SHELTER EXPENSES  
(Please divide annual expenses by 12)**

Mortgage	\$ _____
Real Estate Taxes	\$ _____
Water	\$ _____
Sewer	\$ _____
Utilities (Heat, Electric & Telephone)	\$ _____
Homeowner's insurance premium	\$ _____
Condominium fees	\$ _____
<b>Total Monthly Housing Expenses</b>	\$ _____

**F. MONTHLY NON-SHELTER LIVING EXPENSES**

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

**GIFTS**

**G.**

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 \_\_\_\_\_

Yes  No

Have you ever filed a Federal Gift Tax Return?

If yes, please state details \_\_\_\_\_

**H. CHILDREN**

**Name of Child** \_\_\_\_\_ **Gender:**  Male  Female

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

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

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

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship to Husband:  Natural child  Adopted  
 Stepchild  Child born out of wedlock  
 Relationship to Wife:  Natural child  Adopted  
 Stepchild  Child born out of wedlock

**Name of Child** \_\_\_\_\_ Gender:  Male  Female

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

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

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

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

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

Relationship to Husband:  Natural child  Adopted

Stepchild  Child born out of wedlock

Relationship to Wife:  Natural child  Adopted

Stepchild  Child born out of wedlock

**Name of Child** \_\_\_\_\_ Gender:  Male  Female

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

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

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

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Relationship to Husband:  Natural child  Adopted

Stepchild  Child born out of wedlock

Relationship to Wife:  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?       Medicaid       Medicare

Do any of your family members have any problems with:

AIDS?       Yes       No

Drug Addiction?       Yes       No

Alcoholism?       Yes       No

Spendthrift?       Yes       No

Marital Difficulty?       Yes       No

Do any of your children live with you in your home?      ? Yes       No

If yes, name(s) of child(ren) \_\_\_\_\_

Are you a contributor to a 529 Plan?       Yes       No

If yes, please attach a statement of the 529 account.

**I. CONTACT PERSON**

Name \_\_\_\_\_

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

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

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

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

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

**J. MISCELLANEOUS**

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

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

\_\_\_\_\_

\_\_\_\_\_

**K. REFERRAL**

By Whom Were You Referred To This Office?

Name \_\_\_\_\_

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

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

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

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

Referral is:       Attorney               Financial Planner               Doctor  
                          Previous Client of Personal Legal Plans               Other

**L. CERTIFICATION**

The undersigned hereby represents to Conrad Trosch & Kemmy, P. A., 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:

\_\_\_\_\_

Clients' Names: \_\_\_\_\_

**ASSETS/LIABILITIES**

List your own and your spouse's property with estimated fair market values in the broad categories provided. If asset is owned by Husband, enter the value in Husband's column; if by Wife, in Wife's column; if owned jointly, enter value in Joint column. If an asset has a lien on it, enter that in the Liabilities column.

<b>ASSETS</b>	<b>HUSBAND</b>	<b>WIFE</b>	<b>JOINT</b>	<b>LIABILITIES</b>
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING				
SAVINGS				
MONEY MARKET				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE) Address:				
OTHER REAL ESTATE Address:				
ADDITIONAL AUTOMOBILES				
BROKERAGE/CAP ACCOUNTS				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE—LIFE INSURANCE				
TRADITIONAL IRA/RETIREMENT PLANS				
ROTH IRA				
NURSING HOME DEPOSIT				
PREPAID FUNERAL				
OTHER:				
OTHER:				
TOTAL:				