MEDICAID WORKSHEET #4

Conrad Trosch & Kemmy, P.A.

CONRAD TROSCH & KEMMY, P. A.

ASSET PROTECTION 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. Please 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
Was Spouse a Veteran? ☐ Yes ☐ No

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

If Widowed, Name of Deceased Spouse: _____
Date of Death: _____

B. MEDICAL DATA

1. HEALTH

Diagnosis_____

If already entered a nursing home:

Name of Nursing Home_____

Date Entered_____

2. PHYSICIAN

Full Name of Primary

Physician_____

Street Address_____

City_____ State_____

Zip_____

C. ASSETS

[Complete Attached Schedule of Assets/Liabilities.]

D. MONTHLY INCOME

Monthly Income	Monthly Income
Net Social Security Benefits	$_____
Employment Income (if applicable)	$_____
Retirement Benefits (Gross)	$_____
Disability Benefit	$_____
Annuity Income	$_____
Other Income	$_____
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.**

E. MONTHLY SHELTER EXPENSES

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

Mortgage	$_____
Real Estate Taxes	$_____
Water	$_____
Sewer	$_____
Utilities (Heat, Electric & Telephone)	$_____
(1/12th of last 12 months)	
Homeowner's insurance premium	$_____
Condominium fees	$_____
Total Monthly Housing Expenses	$_____

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	$_____

G. 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_____

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

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: ☐ 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: ☐ 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: ☐ 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

☐ Previous Client of Personal Legal Plans ☐ Doctor

Have you visited our Website at www.ctklawyers.com ? ☐ Yes ☐ No

Do you have any ideas for improving our Website? If so, please discuss.

_____

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, its individual lawyers, and possibly third party providers 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:

_____

Client's Name: _____

ASSETS/LIABILITIES

List your property with estimated fair market values in the broad categories provided. If an asset has a lien on it, enter that in the Liabilities column.

ASSETS	VALUE	LIABILITIES
PERSONAL EFFECTS		
AUTOMOBILE		
CHECKING		
SAVINGS		
MONEY MARKET		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) Address:		
OTHER REAL ESTATE (ASSESSED VALUE) Address:		
OTHER REAL ESTATE (ASSESSED VALUE) Address:		
OTHER REAL ESTATE (ASSESSED VALUE) 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:		
TOTALS		