MEDICAID PLANNING QUESTIONNAIRE
(MARRIED)

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

(Husband)
Full Name_____
(print name as shown on your checks)

(Wife)
Full Name_____
(print name as shown on your checks)

Street Address_____

City_____ State_____ Zip_____

(Husband)
Birth Date_____

(Wife)
Birth Date_____

Social Security No._____

Social Security No._____

U.S. Citizen? G Yes G No
Veteran? G Yes G No

U.S. Citizen? G Yes G No
Veteran? G Yes G No

If you or your spouse is a Veteran, are you receiving Tricare? G Yes G 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_____

Health of Well Spouse_____

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_____

3. STATE PHARMACEUTICAL PLANS

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior GOLD? G Yes G No

If you are a Pennsylvania resident, are you currently receiving benefits under PACE or PACE NET? G Yes G No

If you re a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? G Yes G No

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Net Social Security Benefits	$_____	$_____
Medicare Part B Deduction	G $93.50 G $106.00 G $143.40 G $162.10	G $93.50 G $106.00 G $143.40 G $162.10
Co-pay Medicare Part D (if applicable)	$_____	$_____
Retirement Benefits (Gross)	$_____	$_____
VA Disability Benefit	$_____	$_____
Annuity Income	$_____	$_____
Rental 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.**

D. MONTHLY SHELTER EXPENSES

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

Rent/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	$_____

E. 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	$_____

F. GIFTS

Have you made any gifts within the last five years to an individual or to a trust? G Yes G No

If yes, list below:

Recipient_____ Date _____ Amount

Recipient_____ Date _____ Amount

Recipient_____ Date _____ Amount

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

If yes, please state details

_____

_____

_____

G. CHILDREN (if applicable, include adult and minor children)

Name of Child_____ Gender: G Male G Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

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

Name of Child______________________________ Gender: G Male G Female

Street Address____

City______________________________ State______________ Zip__________

Home Phone Number______________ Work Phone Number____________________

Date of Birth__________________ Social Security Number__________________

E-mail Address____

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

Name of Child______________________________ Gender: G Male G Female

Street Address____

City______________________________ State______________ Zip__________

Home Phone Number______________ Work Phone Number____________________

Date of Birth__________________ Social Security Number__________________

E-mail Address____

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

Name of Child______________________________ Gender: G Male G Female

Street Address____

City______________________________ State______________ Zip__________

Home Phone Number______________ Work Phone Number____________________

Date of Birth__________________ Social Security Number__________________

E-mail Address____

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

Name of Child_____ Gender: G Male G Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

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

Are all of your children in good health? G Yes G No

Are any of your children blind? G Yes G No

Are any of your children disabled? G Yes G No

Are any of your children receiving SSI or other form of government entitlement? G Yes G No

If yes: How much is the child's monthly payment? $_____

Is the child receiving Medicaid or Medicare? G Medicaid G Medicare

Do any of your family members have any problems with:

AIDS?	G Yes G No
Drug Addiction?	G Yes G No
Alcoholism?	G Yes G No
Spendthrift?	G Yes G No
Marital Difficulty?	G Yes G No

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

If yes, name of child_____

Are you a contributor to a 529 Plan? G Yes G No

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

MEDICAID PLANNING -ADDITIONAL INFORMATION

Last Name of Client_____ **File No.**_____

A. ASSETS/LIABILITIES

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING				
SAVINGS				
MONEY MARKET				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE) BLOCK#_____ LOT#_____ EQ. RT _____ REM. FCTR _____				
OTHER REAL ESTATE BLOCK#_____ LOT#_____ EQ. RT _____ REM. FCTR				
ADDITIONAL AUTOMOBILES				

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
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:				
TOTALS				

Residence Information

Purchase Price $_____

Purchase Costs
(title & escrow fees, real estate agent commissions, etc.) + $_____

Improvements + $_____

Selling Costs
(title & escrow fees, real estate agent commissions, etc.) + $_____

Accumulated Depreciation - $_____

Cost Basis = $_____

Have you owned the property for 2 of the last 5 years? G Yes G No

Have you occupied the property for 2 of the last 5 years? G Yes G No

Have you sold property within the last 2 years? G Yes G No

If yes:

What was the cost basis of the property? $_____

What was the sales price? $_____

Have you gifted property? G Yes G No

If yes:

Number of Donees _____

Was it a give from Husband and Wife? G Yes G No

Amount of Unified Credit Available _____

Other Real Property Information

Address of any real property other than personal residence:

(1)Street_____City_____State_____Zip

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $_____

(2)Street_____City_____State_____Zip

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $_____

Name of Homeowner's Insurance Company_____

Street Address_____

City_____ State_____ Zip_____

Phone No._____ Policy No._____

B. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost $_____

Monthly Prescription Cost $_____

Monthly Incontinent Cost $_____

Monthly Medical Insurance Cost (Ill Spouse Only) $_____

Monthly Other Cost $_____

Total Monthly Cost $_____

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

C. LIFE INSURANCE

Name of Insurance Company_____ Policy #_____

Street Address_____

City_____ State_____ Zip_____

Type of Policy_____ Owner_____

Insured_____ Beneficiary_____

Death Benefit: $_____ Face Value: $_____ Cash Value: $_____

Name of Insurance Company ____________________ Policy #__________

Street Address ____

City ____________________ State _____________ Zip__________

Type of Policy ______________ Owner ________________________

Insured ___________________ Beneficiary ____________________

Death Benefit: $_______ Face Value: $___________ Cash Value:$_______

Name of Insurance Company ____________________ Policy #__________

Street Address ____

City ____________________ State _____________ Zip__________

Type of Policy ______________ Owner ________________________

Insured ___________________ Beneficiary ____________________

Death Benefit: $_______ Face Value: $___________ Cash Value:$_______

Name of Insurance Company ____________________ Policy #__________

Street Address ____

City ____________________ State _____________ Zip__________

Type of Policy ______________ Owner ________________________

Insured ___________________ Beneficiary ____________________

Death Benefit: $_______ Face Value: $___________ Cash Value:$_______

Name of Insurance Company ____________________ Policy #__________

Street Address ____

City ____________________ State _____________ Zip__________

Type of Policy ______________ Owner ________________________

Insured ___________________ Beneficiary ____________________

Death Benefit: $_______ Face Value: $___________ Cash Value:$_______

H. CONTACT PERSON

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Cell Number _____ Fax Number _____

E-mail Address _____

I. MISCELLANEOUS

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

If yes, please explain

_____

_____

J. REFERRAL

By Whom Were You Referred To This Office?

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Cell Number _____ E-mail Address _____

Referral is: ☐ Attorney ☐ Financial Planner

☐ Previous Client of Scott M. Hanula, Esquire ☐ Doctor

☐ Social Worker Other _____

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

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

K. CERTIFICATION

The undersigned hereby represents to Scott M. Hanula, Esquire that the information contained in this intake form is accurate and complete, and that the undersigned understands that Scott M. Hanula, Esquire 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: