

**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 \_\_\_\_\_ **(Wife)** Full Name \_\_\_\_\_  
(print name as shown on your checks) (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      U.S. Citizen?      G Yes      G No  
Veteran?          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 are 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	\$ _____	\$ _____
<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.**

**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	\$ _____
<b>Total Monthly Housing Expenses</b>	<b>\$ _____</b>

**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	\$ _____
<b>Total Monthly Non-Shelter Living Expenses</b>	<b>\$ _____</b>

**F. 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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 \_\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_\_\_

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

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 of child \_\_\_\_\_

Are you a contributor to a 529 Plan?  Yes  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:				
<b>TOTALS</b>				

**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](http://www.hanulalaw.com)?  Yes  No

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

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**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:

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