

(2) _____
First Name MI Last Name Age Address (street, town, state and zip) Telephone

Spouse's Name Names and Ages of Grandchildren

(3) _____
First Name MI Last Name Age Address (street, town, state and zip) Telephone

Spouse's Name Names and Ages of Grandchildren

(4) _____
First Name MI Last Name Age Address (street, town, state and zip) Telephone

Spouse's Name Names and Ages of Grandchildren

MEDICAL/DISABILITY

Is anyone in your family disabled? Yes__ No__

If yes, please explain (include relationship): _____

Is anyone at risk for becoming seriously ill or disabled because of a medical condition or family history? Yes__ No__

If yes, please explain: _____

Doctor: _____
Name Address

Spouses' Doctor: _____
Name Address

Has anyone in your family recently entered a hospital or skilled nursing facility? Yes__ No__ Daily Charge: \$_____

Name of Facility: _____ Date of Admission: _____

Date of Discharge: _____ Diagnosis: _____

HEALTH INSURANCE

	<u>You</u>	<u>Spouse</u>	<u>Effective Dates</u>
Medicare	_____	_____	_____
	Number	Number	
Insurance from Employer	_____	_____	_____
Medicare Supplement	_____	_____	_____
Long-Term Care Insurance	_____	_____	_____
Other	_____	_____	_____

FINANCIAL

Income Producing Assets:

Bank Accounts, CDs, Brokerage Accounts, Stocks, Corporate or U.S. Bonds, other:

Description & Location of Property **Value** **Acct. No.** **In Whose Name?**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TOTAL: _____

Have you or your spouse made any transfers or gifts of \$2,000 or more during the past five years?

Yes__ No__

If yes: Date: _____ Value: _____ To Whom/Relationship _____

Date: _____ Value: _____ To Whom/Relationship _____

Date: _____ Value: _____ To Whom/Relationship _____

Date: _____ Value: _____ To Whom/Relationship _____

Real Estate:

<u>Description of Property</u>	<u>Date of Purchase</u>	<u>Purchase Price</u>	<u>Estimated Value</u>	<u>In Whose Name?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Who else lives in the house? _____ How long? _____

Relationship: _____

Do you or your spouse have an interest in any business?

Yes__ No__

Monthly Income:

	<u>You</u>	<u>Your Spouse</u>	<u>Joint</u>
Social Security	_____	_____	_____
Employment	_____	_____	_____
Pension from _____	_____	_____	_____
IRA's, Annuities, etc. _____	_____	_____	_____
Business Interests _____	_____	_____	_____
Other _____	_____	_____	_____
TOTALS:	_____	_____	_____

(If you need more room, please attach a sheet or a second copy of this page).

Which sources of income have a benefit for a surviving spouse?

Life Insurance:

<u>Whose Life? /Type</u>	<u>Company</u>	<u>Face Value</u>	<u>Cash Value</u>	<u>Policy No.</u>	<u>Beneficiary</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other Property with Designated Beneficiaries:

Do you have IRAs, vested pension plans, annuities, or other assets that would pass on your death to a particular beneficiary that you have designated?

<u>Description</u>	<u>Value</u>	<u>Designated Beneficiary</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you or your spouse expect an inheritance? Yes__ No__

Are you or your spouse the beneficiary of any trust? Yes__ No__

If yes, from which estate/trust: _____

Liabilities (mortgages, notes to banks, notes to others, loans on insurance, other):

<u>Description</u>	<u>Balance Due</u>	<u>Monthly Payment</u>	<u>Maturity Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Location of important papers: _____

PERSONAL PROPERTY (Autos, RVs, boats, heirlooms, jewelry, collections, etc.)

<u>Description of Property</u>	<u>Value</u>	<u>In Whose Name?</u>	<u>Insured?</u>
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__
_____	_____	_____	Y__ N__

MONTHLY EXPENSES (Average)

HOUSING

Rent/Mortgage _____
Property Taxes _____
Insurance _____
Telephone _____
Cable TV _____
Electric/Gas _____
Water/Sewage _____

AUTOMOBILE

Loan Payments _____
Insurance _____
Gas/Oil _____
Maint/Repairs _____

Maintenance/Repair _____

Other (specify) _____

DEBTS

Credit Cards _____

Others _____

MEDICAL

Insurance _____

Doctor/Dentist _____

Prescriptions _____

Home Health Care _____

CLOTHING

Purchases _____

Cleaners _____

MISCELLANEOUS

Gifts _____

Food _____

Other _____

Other _____

ENTERTAINMENT/RECREATION

Vacation _____

Dining Out _____

Clubs/Memberships _____

NURSING HOME OR HOME HEALTH AIDE

Daily Cost _____

LEGAL

	Date Made	Location of
<i>Original</i>		
Last Will and Testament	_____	_____
Durable Power of Attorney	_____	_____
Living Will/Health Care Proxy	_____	_____
Living Trust	_____	_____

I am the legally appointed guardian of: _____

I have been appointed under a Power of Attorney from: _____

I am serving as executor or administrator of an estate: _____

I am involved in a lawsuit: _____

I have lived in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington), if yes, which?

Other legal concerns: _____

Please bring copies of the following documents with you to your meeting with the attorney:

1. Will, Codicil, Trust Agreements
2. Real Estate Deeds, Appraisals
3. Admission Agreements to Hospitals and Health Facilities
4. Divorce Decrees, Prenuptial Agreements, Adoption Papers
5. Guardianship Documents
6. Living Will, Health Care Declaration or Power of Attorney, Durable Powers of Attorney

A list of full names, addresses, telephone numbers of people who have a part in your planning as executors, trustees, beneficiaries of your estate, helpers and advisors

CLIENT CERTIFICATION

I have provided the above information to the best of my knowledge and ability. I understand that if any of the information is incorrect, or found to be fraudulent, I may be denied services from Medicaid. I also agree to notify the agency as soon as possible should any of the above information change.

Client Name (print): _____

Signature: X: _____ Date: _____