Medicaid Planning
In-Take Questionnaire
(MARRIED)

Date of Interview: _____

Location: _____ **Boynton** **Other:** _____

GENERAL INFORMATION

1	**Client Full Name**	
2	**Client Soc Sec Number**	
3	**Client DOB**	
4	**Client Age**	
5	**Client Home Address**	
6	**Client City, State, Zip**	
7	**Client County**	
8	**Client Home Phone**	
9	**Client Cell Phone**	
10	**Client Work Phone**	
11	**Client Email**	
12	**Client Citizenship**	
13	**Client Veteran OR Widow of Veteran**	

14	**Client Marital Status**	**Married**
15	**Previous Marriage**	Yes_____ No _____ If Yes, divorce date _____
16	**Children from previous marriage?** *(If answered No in #15 above mark N/A)*	Yes_____ No _____ If Yes: Full name of each child age, city and state: 1. 2. 3.

17	**Client Current Will**	Yes_____ No _____ Date_____
18	**Client Trusts**	Yes_____ No _____ Date_____
19	**Client DPOA**	Yes_____ No_____ Date_____
20	**Client HS Surrogate**	Yes_____ No _____ Date _____
21	**Client Living Will**	Yes _____ No _____ Date _____

22	**Disabled Children or Grandchildren**	Yes ____ No ____

	Client - Health Insurance	
23	Client Medicare Coverage	
24	Client MEDIGAP	
25	Client LTC Insurance?	

Client's Current Location and Health Insurance

26	Type of Living Arrangement	
27	Client Location	
28	Phone	
29	Date of admission	
30	Funding Source	Self pay Health Insurance Medicare Medicaid

Client ADL's (Activities of Daily Living)

31	Client's Doctor Doctor Address/Phone	
32	Walk and Stand	Independent Requires Some Assistance Totally Dependent
33	Feed Self	Independent Requires Some Assistance Totally Dependent
34	Dressing Self	Independent Requires Some Assistance Totally Dependent
35	Bath Self	Independent Requires Some Assistance Totally Dependent
36	Toiletry	Independent Requires Some Assistance Totally Dependent
37	Continence	Independent Requires Some Assistance Totally Dependent
38	Transfer	Independent Requires Some Assistance Totally Dependent
39	Dementia	Diagnosis_____
40	General Overall Health	

	Client Rep	
41	Client Rep Acronym	
42	Client Rep Full Name	
43	Client Rep Relation	
44	Client Rep Address	
45	Client Rep City State	
46	Client Rep Zip Code	
47	Client Rep Cell Phone	
48	Client Rep Home Phone	
49	Client Rep Email	
50	Client Rep Soc Sec	

SPOUSE INFORMATION

51	SPOUSE NAME	
52	Spouse previously Married	Previous Marriage? Date of Divorce? Children Previous Marriage?
53	SS #	
54	DOB	
55	Age	
56	Address	
57	City, State Zip	
58	County	
59	Phone	Cell Phone: Home Phone: Work Phone :
60	Spouse Citizenship	
61	Spouse Veteran	
62	Spouse other previous marriages?	If yes date Divorce Previous Marriage

63	Spouse previous marriages?	Yes _____ No _____ If yes date of divorce _____
	Spouse Children from previous marriage?	Yes_____ No _____ If Yes: <u>Full name of each child age, city and state:</u> 1. 2. 3.

CHILDREN OF YOUR CURRENT MARRIAGE

Full Name	Age	Address City State Phone: Email:

Spouse Current Estate Planning Documents

64	**Spouse Current Will**	Yes_____ No _____ Date_____
65	**Spouse Trusts**	Yes_____ No _____ Date_____
66	**Spouse DPOA**	Yes_____ No_____ Date_____
67	**Spouse Healthcare Surrogate**	Yes_____ No _____ Date _____
68	**Spouse Living Will**	Yes _____ No _____ Date _____

69	**Disabled Children or Grandchildren**	Yes ____ No ____

Spouse's Health (Activities of Daily Living)

	Primary Care Doctor Address/Phone			
70	Walk and Stand	Independent	Requires Some Assistance	Totally Dependent
71	Feed Self	Independent	Requires Some Assistance	Totally Dependent
72	Dressing Self	Independent	Requires Some Assistance	Totally Dependent
73	Bath Self	Independent	Requires Some Assistance	Totally Dependent
74	Toiletry	Independent	Requires Some Assistance	Totally Dependent
75	Continence	Independent	Requires Some Assistance	Totally Dependent
76	Transfer	Independent	Requires Some Assistance	Totally Dependent
77	Dementia	YES NO	Diagnosis_____	
78	General Overall Health			

VII. Spouse's Location and Health Insurance

79	Type of facility	Lives at Home/Children Independent Living Hospital CCRC ALF Nursing
80	Address	
81	City State Zip	
82	Phone	
83	Date of admission	
84	Funding Source	Self pay Health Insurance Medicare Medicaid

	Spouse - Health Insurance	
85	Spouse Medicare Coverage	
86	Spouse MEDIGAP	
87	Spouse LTC Insurance?	

LISTING OF ASSETS

Asset	You	Spouse	Joint	TOTAL	Comments
Primary Residence					
1st Mortgage					
Additional Residence					
1st Mortgage					
Vehicle 1					
Owed on Car:					
Vehicle 2					
Owed on car					
Personal Property					
BANK – Savings					
BANK Checking					
Life Insurance Cash Value					
Cemetery Plot					
Funeral Plan					
Burial Fund					
Annuities					
Bonds					
401(k)					
Stocks					
Bus Assets/Rental Prop					
TOTALS					

IX. GROSS MONTHLY INCOME

(Current Market value date of Meeting)

Source	Applicant	Spouse	Joint	TOTAL
GROSS Social Security (Retirement)				
IRA (Traditional)				
IRA (Roth)				
Pension				
CD Income				
VA Pension Aid Attendance				
VA Compensation				
401(k)				
Annuity Income				
Interest				
Dividend				
Gross Total Income				

CASHFLOW ANALYSIS			
	Applicant	**Spouse**	**Total**
TOTAL INCOME			
SHELTER COSTS			
Mortgage Payment			
Home Insurance			
Home Maintenance			
MIP			
Condo/Association Fee			
Property Taxes/Escrowed			
Telephone			
Cable TV			
Miscellaneous Upkeep			
Plumbing/Electric			
Lawn care			
Water/Sewer			
Total Shelter Costs			
DAILY LIVING EXPENSES			
Entertainment			
Food, Care Products			
Gasoline			
Car Payment			
Auto Insurance			
Life Insurance premiums			
Temple/Church Dues			
Housekeeper Services			
Credit Card Pmts			
Other Taxes			
Total Daily Living Expenses			
HEALTH CARE COSTS			
Health Ins Supplement			
Care Asst/Mgr/Nurse			
NH / ALF Pat Responsibility			
Adult Day Care Services			
Co-Pays			
Med Supplies			
Non-Prescription Drugs			
Prescription Drugs			
Total Health Care Costs			
GRAND TOTAL EXPENSES			
NET CASH FLOW			

TRANSFERS/GIFTS IN LAST 5 Years
(Include any transfers from accounts held jointly with others)

Asset Transferred	Date Transferred	Amount	To Who/Where

LISTING OF CREDITORS

Creditor Name	Acct #	Date Invoice	Amount
TOTAL			