Medicaid Planning
In-Take Questionnaire

(Single)

Date of Interview: _____________

Location: ______ **Boynton** **Other:** __________________

CLIENT GENERAL INFORMATION

1)	**Applicant full Name**	
2)	Alias / Maiden Names	
3)	Marital Status	**Single** **Married** **Separated** **Divorced** **Widow**
4)	Previous marriages	No____ Yes _____ If yes, date and disposition ______________________________
5)	Soc Sec Number	
6)	DOB	
7)	Home Address	
8)	City, State, Zip	
9)	County	
10)	Phone	Home:__________________ Wk:____________________ Cell:_____________________
11)	E Mail Address	
12)	Citizenship	U.S.A OTHER__________________
13)	Veteran	Yes ____ No_____ Date Discharge _________________
14)	Health Insurance	______ Traditional Medicare (Red, White Blue card) _______ HMO/Managed Care Start Date of Benefits: _________________ Medicare #:__________________________________ Medicare PART D Policy? YES_____ NO_____ Monthly Premium_____________
15)	MEDIGAP (Supplement)	NO ___ YES ____ Amt of premium _________________/Month Pay to:____ Address ____ Policy #:____
16)	LTC Insurance?	YES NO If yes, Company:_________________ Type: _________ Daily Ben $______
17)	App Will (Florida)	YES NO Date
18)	App Trusts	YES NO Date
19)	App DPOA (Florida)	YES NO Date
20)	App HS Surrogate	YES NO Date
21)	App Living Will	YES NO Date
22)	Family Members Disabled?	YES NO If, yes: Name:___________________ Relation:___________________

REPRESENTATIVE OF CLIENT CONTACT INFO

23)	**Rep Full Name**	
24)	Relation to Client	____ **Child** _____ **Sibling** **Other:** _______________________
25)	Spouse's name	
26)	Soc Sec Number	
27)	DOB	
28)	Home Address	
29)	City, State, Zip	
30)	County	
31)	Phone	Home:__________________ Wk:____________________ Cell:_____________________
32)	E Mail Address	
33)	Citizenship	U.S.A OTHER__________________

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CHILDREN OF APPLICANT

	Full Name	Age	Address City, State Zip	Phone Email
1				
2				
3				
4				

APPLICANT'S CURRENT LOCATION AND HEALTH INSURANCE

1	Location Contact Person	
2	Living Arrangement	Lives at Home/Children Independent Living Hospital CCRC ALF Nursing
3	Address	
4	City State Zip	
5	Phone	
6	Date started	
7	Funding Source	Self pay Health Insurance Medicare Medicaid

APPLICANT'S HEALTH (ACTIVITIES OF DAILY LIVING)

	Primary Care Doctor Address/Phone	
1	Walk and Stand	Independent Requires Some Assistance Totally Dependent
2	Feed Self	Independent Requires Some Assistance Totally Dependent
3	Dressing Self	Independent Requires Some Assistance Totally Dependent
4	Bath Self	Independent Requires Some Assistance Totally Dependent
5	Toiletry	Independent Requires Some Assistance Totally Dependent
6	Continence	Independent Requires Some Assistance Totally Dependent
7	Transfer	Independent Requires Some Assistance Totally Dependent
8	Dementia	YES NO Diagnosis___________________________________
9	Health Conditions	

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LISTING OF ASSETS

Asset	You	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				

List all homes (less loans), autos (less loans), property, land interests, banks accounts, savings accounts, checking accounts, stocks, bonds, CD's, money market accounts, annuities, life insurance (cash value), funeral plans, burial plots, IRA's.

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MONTHLY

GROSS INCOME

Source	Applicant
GROSS Soc. Security (RIB Retirement)	
IRA	
Pension	
401(k)	
Annuity	
Bank Account Interest	
VA Pension Aid Attendance	
VA Compensation	
Gross Total Income	

(Gross Income means before any deductions for taxes or other benefits)

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MONTHLY CASHFLOW

	Applicant
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	

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TRANSFERS/GIFTS

(Made in the past 5 years)

Asset Transferred	Date Transferred	Amount	To Who/Where

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