Medicaid Planning
In-Take Sheet
(Married)

Date of Interview: ____________________
Location: ______ **Boynton Ofc.** **Other:** ________________

Others Present: ____
____

CLIENT - GENERAL INFORMATION

1	**Gender**	_____ **Male** _______ **Female**
2	**Salutation**	_____ **Mr.** ____ **Mrs.** ______ **Ms** ________ **Dr.**
3	**Full Name**	
4	**Home Address**	
5	**City, State, Zip**	
6	**County**	
7	**Home Phone**	
8	**Cell Phone**	
9	**Work Phone**	
10	**Email**	
11	**Citizenship**	U.S. Citizen & Resident U.S. Resident Other

CLIENT - DETAILED INFO

12	**Soc Sec Number**	
13	**DOB**	
14	**Age**	
15	**Over 55**	_____ YES ____NO
15	**Life Expectancy**	

16	**Client Veteran OR Widow of Veteran**	
17	**Client Widow of Veteran**	

CLIENT – MARITAL HISTORY

18	**Client Marital Status**	**MARRIED**
19	**Children** **CURRENT Marriage**	____ Yes ____ No If Yes: **Full name of each child age, city and state. Disabled?:** 1. ________________________________ 2. ________________________________ 3. ________________________________ 4. ________________________________
19	**Previous Marriage**	Yes No If Yes, divorce date
	Children **PREVIOUS Marriage**	____ Yes ____ No If Yes: **Full name of each child age, city and state. Disabled?:** 1. ________________________________ 2. ________________________________ 3. ________________________________ 4. ________________________________

CLIENT - CURRENT ESTATE PLANNING DOCUMENTS

20	**Client Current Will**	Yes______ No _____ If Yes, Date: _________________ STATE: _______________ Comments:
21	**Client Trusts**	Yes______ No _____ If Yes, Date__________________ STATE: _______________ Comments:
22	**Client DPOA**	Yes______ No______ If Yes, Date__________________ STATE: ________________ Comments:
23	**Client Healthcare Surrogate**	Yes______ No ______ If Yes, Date _______________ STATE: _________________ Comments:
24	**Client Living Will**	Yes _____ No ______ Date ___________________ STATE: _________________ Withhold Nutrition: Yes: ________ No: ________

Client Health Insurance

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

Client 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 - GENERAL INFORMATION

1	**Gender**	______ **Male** _______ **Female**
2	**Salutation**	_____ **Mr.** ____ **Mrs.** ______ **Ms** ________ **Dr.**
1	**Full Name**	
2	**Home Address**	
3	**City, State, Zip**	
4	**County**	
5	**Home Phone**	
6	**Cell Phone**	
7	**Work Phone**	
8	**Email**	
9	**Citizenship**	

SPOUSE - VITALS

12	**Soc Sec Number**	
13	**DOB**	
14	**Age**	
15	**Over 55**	_____ YES ____NO
15	**Life Expectancy**	

16	**Client Veteran OR Widow of Veteran**	
17	**Client Widow of Veteran**	

SPOUSE – MARITAL HISTORY

18	**Client Marital Status**	**MARRIED**
19	**Children** **CURRENT Marriage**	____ Yes ____ No If Yes: **Full name of each child age, city and state. Disabled?:** 1. ________________ 2. ________________ 3. ________________ 4. ________________
19	**Previous Marriage**	____ Yes ____ No If Yes, divorce date _______________
	Children **PREVIOUS Marriage**	____ Yes ____ No If Yes: **Full name of each child age, city and state. Disabled?:** 1. ________________ 2. ________________ 3. ________________ 4. ________________

SPOUSE - CURRENT ESTATE PLANNING DOCUMENTS

1	**Spouse Current Will**	Yes______ No _____ If Yes, Date: ________________ STATE: ______________ Comments:
2	**Spouse Client Trusts**	Yes______ No _____ If Yes, Date________________ STATE: ______________ Comments:
3	**Spouse DPOA**	Yes______ No______ If Yes, Date________________ STATE: _______________ Comments:
4	**Spouse Healthcare Surrogate**	Yes______ No ______ Date ______________ Comments:
5	**Spouse Living Will**	Yes _____ No ______ Date __________________ STATE: ________________ Withhold Nutrition: Yes: ________ No: ________

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

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

VIII. LISTING OF ASSETS

Asset (In Dollars)	You ($$)	Spouse ($$)	Joint (H&W - $$)	Joint (w/ Others - $$)	Comments
Primary Residence					
1st Mortgage					
Additional Residence					
1st Mortgage					
Vehicle 1					
Owed on Car:					
Vehicle 2					
Owed on car					
Bank – Savings					
Bank - Savings					
Bank Check					
Bank Check					
Cemetery Plot					
Funeral Plan					
Burial Fund					
Annuities					
Bonds					
401(k)					
Stocks					
Bus Assets/Rental Prop					
TOTALS					

IX. GROSS MONTHLY INCOME

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

ADDITIONAL QUESTIONS	Client	Spouse
Where do you keep important papers (Wills, Insurance policies)		
Do you have safe deposit box (Location) Names who have access		
Expecting any inheritances (When how much form whom)		
Gift tax returns ever filed? Ever give gifts to any one person exceeding $10,000?		
Are you do you have a power of appointment or are you named as a personal representative in anyone else's Will or named trustee?		
Are you party to buy-sell agreement, stock option plan, salary continuation plan, or deferred compensation plan. (not pension or profit sharing plan)		

COMMENTS/NOTES