Medicaid Planning
In-Take Sheet
(Single)

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**	**SINGLE**
19	**Children**	____ 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 _____

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	

VIII. LISTING OF ASSETS

Asset (In Dollars)	You ($$)	Joint (w/ Others - $$)	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	TOTAL (Gross $$)
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
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)	

	Applicant	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		

XI. TRANSFERS IN LAST 60 MONTHS

(Include any transfers from accounts held jointly with others)

Asset Transferred	Date Transferred	Amount	To Who/Where

COMMENTS/NOTES