Medicaid Planning
Consult Information 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**	(Optional)
13	**DOB**	
14	**Age**	

15	**Client Veteran or Spouse of a Veteran**	_____ Yes _____ No

16	**How did you learn about us**	____ Referred _____ Internet ____ Facebook ____ GG law firm website ____ Print Ad _____ Direct Mail
17	**If you were referred, who referred you**	

CLIENT – MARITAL HISTORY

18	**Client Marital Status**	**Date of Marriage** _____
19	**Children From CURRENT Marriage** **Yes** _____ **No** _____	**Child Full Name – Age - City/State. Note if Disabled:** 1. _____ _____ _____ [ ] Disabled 2. _____ _____ _____ [ ] Disabled 3. _____ _____ _____ [ ] Disabled 4. _____ _____ _____ [ ] Disabled
20	**Previous Marriage?**	____ Yes ____ No If Yes, divorce date _____
21	**Children From PREVIOUS Marriage** **Yes** _____ **No** _____	**Child Full Name – Age - City/State. Note if Disabled:** 1. _____ _____ _____ [ ] Disabled 2. _____ _____ _____ [ ] Disabled 3. _____ _____ _____ [ ] Disabled 4. _____ _____ _____ [ ] Disabled

CLIENT REP

	Client Rep	
22	Client Rep Acronym	
23	Client Rep Full Name	
24	Client Rep Relation	_____ Spouse _____ Child _____ Relative _____ Other
25	Client Rep Address	
26	Client Rep City State	
27	Client Rep Zip Code	
28	Client Rep Cell Phone	
29	Client Rep Home Phone	
30	Client Rep Email	

CLIENT - CURRENT ESTATE PLANNING DOCUMENTS

31	**Client Current Will?**	Yes_____ No _____ If yes, date: _____ STATE: _____ Comments: _____
32	**Client Have any Trusts?**	Yes_____ No _____ If Yes, Date_____ STATE: _____ Comments: _____
33	**Client Have Durable Power of Attorney?**	Yes_____ No_____ If Yes, Date_____ STATE: _____ Comments: _____
34	**Client Have Health Care Directive?**	Yes_____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
35	**Client Have Living Will?**	Yes _____ No _____ If Yes Date _____ STATE: _____ Withhold Nutrition: Yes: _____ No: _____

Client Health Insurance

	Client - Health Insurance	
36	Client Have Medicare Coverage	_____ Yes _____ No If yes: _____ Traditional Medicare _____ Managed Care or PPO
37	Client Have Medicare Supplement Insurance?	Medicare Supplement Insurance _____ Yes _____ No If Yes: Company:_____ Monthly Premium: _____ Medicare Part D Coverage _____ Yes ____ No If Yes, Company: _____ Monthly Premium: $_____
38	Client LTC Insurance?	_____ Yes ____ No

Client Current Location and Health Insurance

39	Type of Living Arrangement	_____ Home _____ Hospital _____ ALF _____ Nursing Home _____ Other
40	Client Location Name and Address (If not home)	
41	Phone	
42	If in Nursing home or Hospital Date of admission	
43	If in Nursing Home, ALF or Hospital – Fund Source	____ Self-Pay _____ Health Insurance _____ Medicare _____ Medicaid

Client ADL's (Activities of Daily Living)

44	Client's Doctor Doctor Address/Phone	
45	Walk and Stand	Independent Requires Some Assistance Totally Dependent
46	Feed Self	Independent Requires Some Assistance Totally Dependent
47	Dressing Self	Independent Requires Some Assistance Totally Dependent
48	Bath Self	Independent Requires Some Assistance Totally Dependent
49	Toiletry	Independent Requires Some Assistance Totally Dependent
50	Continence	Independent Requires Some Assistance Totally Dependent
51	Transfer	Independent Requires Some Assistance Totally Dependent
52	Dementia Diagnosis	_____ No _____ Yes Diagnosis_____
53	General Overall Health	

	Client Rep	
54	Client Rep Acronym	
55	Client Rep Full Name	
56	Client Rep Relation	_____ Spouse _____ Child _____ Relative ____ Other
57	Client Rep Address	
58	Client Rep City State	
59	Client Rep Zip Code	
60	Client Rep Cell Phone	
61	Client Rep Home Phone	
62	Client Rep Email	

SPOUSE - 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: _____

SPOUSE - VITALS

12	**Soc Sec Number**	(Optional)
13	**DOB**	
14	**Age**	

15	**Veteran or Spouse of a Veteran**	_____ Yes _____ No

SPOUSE – MARITAL HISTORY

16	**Previous Marriage**	____ Yes ____ No If Yes, Divorce date _____
17	**Children PREVIOUS Marriage** **Yes** _____ **No** _____	**Child Full Name – Age - City/State. Note if Disabled:** 1. _____ _____ _____ [ ] Disabled 2. _____ _____ _____ [ ] Disabled 3. _____ _____ _____ [ ] Disabled 4. _____ _____ _____ [ ] Disabled

SPOUSE - CURRENT ESTATE PLANNING DOCUMENTS

18	**Client Current Will?**	Yes_____ No _____ If yes, date: _____ STATE: _____ Comments: _____
19	**Client Have any Trusts?**	Yes_____ No _____ If Yes, Date_____ STATE: _____ Comments: _____
20	**Client Have Durable Power of Attorney?**	Yes_____ No_____ If Yes, Date_____ STATE: _____ Comments: _____
21	**Client Have Health Care Directive?**	Yes_____ No _____ If Yes, Date _____ STATE: _____ Comments: _____
22	**Client Have Living Will?**	Yes _____ No _____ If Yes Date _____ STATE: _____ Withhold Nutrition: Yes: _____ No: _____

Spouse Health Insurance

	Spouse - Health Insurance	
23	Spouse Have Medicare Coverage	_____ Yes _____ No If yes: _____ Traditional Medicare _____ Managed Care or PPO
24	Spouse Have Medicare Supplement Insurance?	Medicare Supplement Insurance _____ Yes _____ No If Yes,: Company:_____ Monthly Premium: _____ Medicare Part D Coverage _____ Yes ____ No If Yes, Company: _____ Monthly Premium: $_____
25	Spouse LTC Insurance?	_____ Yes ____ No

Spouse Current Location and Health Insurance

26	Type of Living Arrangement	_____ Home _____ Hospital _____ ALF _____ Nursing Home _____ Other
27	Spouse Location Name and Address (If not home)	
28	Phone	
29	If in Nursing home or Hospital Date of admission	
30	If in Nursing Home, ALF or Hospital – Fund Source	____ Self-Pay _____ Health Insurance _____ Medicare _____ Medicaid

Spouse ADL's (Activities of Daily Living)

31	Spouse 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	

LISTING OF ASSETS

(CONFIDENTIAL)

List all of the assets owned with current balance. It is important to be as accurate as possible. Include all bank checking, savings, and money market accounts, brokerage accounts, CD's, Bonds, Annuities, Life Insurance – Current Cash Surrender Value, Retirement Accounts current value.

Asset (In Dollars)	Client ($$)	Spouse ($$)	Joint (H&W - $$)	Joint (w/ Others - $$)	Comments
Primary Residence					**Purchase Date:** **Price:**
1st Mortgage					**Orig Amount:** **Balance:**
Additional Residence					**Purchase Date:** **Price:**
1st Mortgage					**Orig Amount:** **Balance:**
Auto 1 **Make**_____ **Model:** _____ **Year:** _____					**Mileage**
Owed on Auto 1					
Auto 2 **Make**_____ **Model:** _____ **Year:** _____					**Mileage**
Owed on car					
Bank Acct					
Bank Acct					
Bank Acct					
Bank Acct					
Life Insurance					
CD 1					
CD 2					
IRA 1 (Current Value)					
IRA 2 (Current Value)					
401(k) (Current Value)					
Cemetery Plot					
Funeral Plans					
Annuity Value					
Bonds					
Bus Assets/Rental Prop					
TOTALS					

GROSS MONTHLY INCOME

(CONFIDENTIAL)

List all sources of income. Be sure to list the Gross Monthly Income (Amount before any deductions).

Source	Client (Monthly Gross $$)	Spouse (Monthly Gross $$)	TOTAL
GROSS Social Security (Retirement)			
IRA (Traditional) – Distributions			
GROSS Pension Amount			
Interest			
Dividends			
Gross 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 from whom)		
Gift tax returns ever filed? Ever give gifts to any one person exceeding $15,000?		

Cash Flow Analysis MONTHLY				
	Client Only	**Spouse Only**	**Together**	**TOTAL**
TOTAL MONTHLY GROSS INCOME (All Sources)				
SHELTER COSTS				
Mortgage Payment				
Property Taxes				
Home Insurance				
Condo/Assoc. Dues				
Electric				
Water/Sewer				
Cable TV				
Telephone				
Other: _____				
Other:_____				
Total Shelter Costs				
OTHER EXPENSES				
Food				
Entertainment				
Auto Payment				
Auto Insurance				
Gasoline				
Credit Card Pmts				
Other: _____				
Other: _____				
Other _____				
Total Other Expenses				
HEALTH CARE COSTS				
Medicare Part B Premium				
Medicare Part D Premium				
Health Insurance Supplement				
Care Managers/Nurse Services				
Co-Pays and Deductibles				
Other: _____				
Other:_____				
Total Health Care Costs				
Other: _____				
Other: _____				
GRAND TOTAL EXPENSES				
NET CASH FLOW				
Income taxes Paid - Last year				
Other Taxes:_____				
Other: _____				

TRANSFERS, GIFTS, OR SALES OF IN LAST 60 MONTHS

(Include any transfers from accounts held jointly with others)

(CONFIDENTIAL)

Asset Transferred or Sold	Date Transferred	Amount	To Who/Where

DEBTS

(CONFIDENTIAL)

Type of Debt	Date Transferred	Amount	To Who/Where
Credit Card 1 - _____			
Credit Card 2 - _____			
Credit Card 3 - _____			

COMMENTS/NOTES