Miorini Law PLLC
Attorneys and Counselors at Law

Estate Planning & Asset Protection
Probate and Trust Administration
Elder Law – Special Needs
Long-Term Care Planning – Medicaid
Veterans Benefits – Aid & Attendance
International Tax

QUESTIONNAIRE FOR A COUPLE

ELDER LAW & MEDICAID PLANNING

THE INFORMATION YOU PROVIDE IN THIS QUESTIONNAIRE WILL BE USED TO HELP YOU ORGANIZE YOUR PERSONAL AND FINANCIAL INFORMATION SO THAT WE CAN PROPERLY ASSESS YOUR CURRENT SITUATION AND EVALUATE WHAT SERVICES ARE APPROPRIATE FOR YOU. THE INFORMATION REQUESTED IN THIS FORM IS ESSENTIAL IN ORDER FOR US TO GIVE YOU PROPER ADVICE AND RECOMMENDATIONS.

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL.

IF POSSIBLE, PLEASE RETURN THE COMPLETED WORKSHEET TO OUR OFFICE PRIOR TO YOUR APPOINTMENT VIA E-MAIL, MAIL OR FAX.

Personal Information

Husband:

Name: _____

Cell phone: _____

Work phone: _____

Can we call you at work? ☐ *Yes* ☐ *No*

Email address: _____

Can we email documents? ☐ *Yes* ☐ *No*

Date of Birth: _____

Place of Birth: _____

Social Security Number: _____

Are you a U.S. Citizen? ☐ *Yes* ☐ *No*

Are you a military veteran? ☐ *Yes* ☐ *No*

Date of Service:_____

Wife:

Name: _____

Cell phone: _____

Work phone: _____

Can we call you at work? ☐ *Yes* ☐ *No*

Email address: _____

Can we email documents? ☐ *Yes* ☐ *No*

Date of Birth: _____

Place of Birth: _____

Social Security Number: _____

Are you a U.S. Citizen? ☐ *Yes* ☐ *No*

Are you a military veteran? ☐ *Yes* ☐ *No*

Date of Service:_____

Address:_____

Home Phone: _____

There are two reasons to protect assets: (1) to improve the quality of your own care when needed in the future or (2) to preserve inheritance for your children. Please rate the relative importance of these two reasons from 1 to 5, 1 meaning that it is extremely important to you to get the best possible care and 5 meaning that it is extremely important to you to leave an inheritance.

/ 1 / ☐ */ 2 /* ☐ */ 3 /* ☐ */ 4 /* ☐ */ 5 /* ☐

Enhance my long-term care *Preserve my inheritance*

Do you have any dependents? ☐ *Yes* ☐ *No*

*Who?*_____

Do any of your children have a major disability? ☐ *Yes* ☐ *No*

*Who?*_____

Does he/she receive Supplemental Security Income and/or Medicaid benefits? ☐ *Yes* ☐ *No*

Information About the Health of Husband

What are the current medical or health problems?

_____

_____

What are the medical or health problems that have occurred in the past?

_____

_____

Please list all of the medication taken.

Medication	Reason for taking this drug:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Does your family have a history of health problems (i.e., heart disease, cancer, or Alzheimer's disease)? Describe: _____

_____

_____

Your mother died at the age of _____ The cause of her death was:_____

Your father died at the age of _____ The cause of his death was:_____

Personal Physicians:

Name:_____ Specialty:_____ Address: _____ _____ Phone: _____	Name:_____ Specialty:_____ Address: _____ _____ Phone: _____
Name:_____ Specialty:_____ Address: _____ _____ Phone: _____	Name:_____ Specialty:_____ Address: _____ _____ Phone: _____

Information About the Health of Wife

What are the current medical or health problems?

_____

_____

What are the medical or health problems that have occurred in the past?

_____

_____

Please list all of the medication taken.

Medication	Reason for taking this drug:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Does your family have a history of health problems (i.e., heart disease, cancer, or Alzheimer's disease)? Describe: _____

_____

_____

Your mother died at the age of _____ The cause of her death was:_____

Your father died at the age of _____ The cause of his death was:_____

Personal Physicians:

Name:_____ Specialty:_____ Address: _____ _____ Phone: _____	Name:_____ Specialty:_____ Address: _____ _____ Phone: _____
Name:_____ Specialty:_____ Address: _____ _____ Phone: _____	Name:_____ Specialty:_____ Address: _____ _____ Phone: _____

Functional Limitations

The term "activities of daily living" refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help form either other people, devices (such as a walker or wheelchair) or both. The more assistance people need with their daily activities, the more likely they are to be admitted to a nursing home, other assisted living arrangement, use paid home care; or need hospital care and doctors.

Functional Limitation Regarding Husband

Activities	No Help	Some Help	Can't Do	Instrumental Activities	No Help	Some Help	Can't Do
Bathing				Using telephone			
Dressing				Grocery Shopping			
Transferring from bed to chair				Getting out by car or public transportation			
Walking				Preparing Meals			
Feeding self				Doing housework/handyman work			
Using the Toilet				Doing laundry			
Grooming				Taking Medication			
				Managing Money			

List the name(s) of any persons(s) or agency providing assistance or caregiving for you:

_____

Functional Limitation Regarding Wife

Activities	No Help	Some Help	Can't Do	Instrumental Activities	No Help	Some Help	Can't Do
Bathing				Using telephone			
Dressing				Grocery Shopping			
Transferring from bed to chair				Getting out by car or public transportation			
Walking				Preparing Meals			
Feeding self				Doing housework/handyman work			
Using the Toilet				Doing laundry			
Grooming				Taking Medication			
				Managing Money			

List the name(s) of any persons(s) or agency providing assistance or caregiving for you:

_____

Place where you live:

Single-family home or town home . . . . . □ Husband; □ Wife
Same, but someone assists you there with above activities □ Husband; □ Wife
Apartment in retirement living community . . . . . □ Husband; □ Wife
Assisted Living Facility . . . . . □ Husband; □ Wife
Nursing Home . . . . . □ Husband; □ Wife
Other: _____ □ Husband; □ Wife

Income

	Husband	Wife	Joint
Monthly Social Security Income			
Monthly Retirement Income other than Social Security (IRA, 401(k), etc.)			
Monthly Investment & other income			

Resources

The husband or wife column is for assets owned solely by the husband or the wife or by a living trust of the husband or wife. The joint column is for assets titled jointly in the name of husband and wife, or in a joint living trust. The approximate value of each asset owned should appear in only one of the columns.

Assets	Husband	Wife	Joint
Real Estate			
Checking Accounts			
Savings Accounts			
Investment Assets- Non Retirement (Stocks, Bonds, CD's, Mutual Funds, Brokerage Accounts)			
Retirement Assets (IRA, 401(k), 403(b), Deferred Annuities, Thrift Savings)			
Life Insurance			
Business Interest			
Anticipated Inheritance			
Other			
Total			
Liabilities:			
Net Total			

EXPENSES

Amount	Monthly Expenses
	Mortgage/Rent
	Property tax
	Home Maintenance and Upkeep
	Homeowners Insurance
	Utilities (gas, electric, water & sewer, security)
	Residential Facility
	Private Health care services
	Telephone
	Cable television
	Auto Operation (Gas and Maintenance
	Auto Insurance
	Clothing
	Groceries and Other Household
	Hair Cuts, Personal Grooming
	Laundry and Cleaning
	Checking Account Charges/Bank Fees
	Newspapers and Magazines
	Recreation, vacation, Entertainment
	Health Insurance (such as Medicare supplement)
	Unreimbursed Medical Expenses (such as for drugs)
	Life Insurance
	Charitable Contribution
	Total Monthly Expenses
	Anticipated maintenance and/or improvement needed for your home (e.g., roof, siding, windows, painting, repairs, driveway, etc.):
	Total of Anticipated maintenance and/or improvement

Cost in Connection with Nursing Home:

Monthly Nursing Home Cost	
Monthly Prescription Cost	
Monthly Incontinent Cost:	
Monthly Other Cost:	
Total	

Money You Owe: Creditor's Name and Amount Owed

_____

_____

_____

Gifts and Transfers

Have you made any gifts or transfers, totaling greater than $500 to any individual, charity, or trust within the last **60 months**? If yes, please furnish the indicated information for each gift or transfer (use additional pages if necessary):

To Whom: _____ Date of Gift: _____ Item: _____ Value: _____	To Whom: _____ Date of Gift: _____ Item: _____ Value: _____
To Whom: _____ Date of Gift: _____ Item: _____ Value: _____	To Whom: _____ Date of Gift: _____ Item: _____ Value: _____

- Have you, in the past 5 years, paid money for someone else's benefit (for example, paying for a child's wedding, paying for a grandchild's education, etc.) □ Yes □ No
- Have you made any loans that are still outstanding? □ Yes □ No
- Have you lost any money gambling in the past 5 years? □ Yes □ No
- Have you ever filed a federal gift tax return? □ Yes □ No If yes, please provide a copy

Public Benefits and Community Services

In addition to Social Security and Medicare, are you receiving any other form of assistance, whether form the government, charitable organizations, churches, or volunteer organizations? (Veterans benefits, Section 8 housing, Medicaid, TRICARE for life, Meals-On-wheels, subsidized transportation services, adult day care, support group services, property tax relief, and drug company discount card programs, etc.)

Provider	**Form of Assistance**

MEDICAID APPLICATION INFORMATION CHECKLIST

	Information Needed for Application:	
1.	U.S. Passport or a copy of the Applicant's birth certificate.	☐
2.	Copy of Applicant's state issued driver's license or identification.	☐
3.	Copy of Applicant's Social Security card.	☐
4.	Copy of the Applicant's Medicare card.	☐
5.	Copy of the Applicant's supplemental health insurance card.	☐
6.	Verification of supplemental health insurance premium. i.e., copy of check stub showing deduction or copy of bank statement showing deduction, etc.	☐
7.	Verification of monthly income (Social Security, pension or any other income). We need the most recent payor statement showing the current gross monthly/annual income. The monthly bank statement is not sufficient; it only reports net income. (To request a copy of the Social Security statement, please use the Social Security Administration's automated system at 800-772-1213.)	☐
8.	Statements for all accounts and investments, including bank accounts, certificates of deposit, savings bonds, annuities, insurance policies, brokerage accounts, nursing home patient fund, etc. held jointly or in the name of the Applicant covering the date(s) of _____ through the application date (to be determined).**	☐
9.	Verification/documentation of all liquidations of accounts and investments, including bank accounts, certificates of deposit, savings bonds, annuities, insurance policies, brokerage accounts, etc. As accounts are closed, we need verification that these accounts have been fully liquidated, as well as verification of where the proceeds have been deposited.	☐
10.	Verification/documentation of any transfers or gifts made within the last 5 years.	☐
11.	Copy of the title and registration for the Applicant's vehicle(s).	☐
12.	Copy of the deed to all real property held jointly or individually by the Applicant, including life estates, vacant land, buildings, timeshares, and mobile homes.	☐
13.	Copy of the current real estate tax assessment for all real property.	☐
14.	Copy of the current homeowner's insurance policy or premium notice for all real property.	☐

15.	Copy of the deed or other documentation for the burial plot(s), pre-paid funeral arrangements or pre-paid burial trusts. **Pre-paid funeral arrangements must be irrevocable - please provide verification of this.**	☐
16.	Does the Applicant have any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies or livestock? **Yes / No (please circle)**	☐
17.	Education: Confirm the last grade that the Applicant completed _____ High School or GED Graduate? **Yes / No (please circle)**	☐
18.	Marital Status (please check one): ___ Never Married ___ Divorced ___ Widowed ___ Separated	☐
19.	Please verify the address of the Applicant prior to entering a nursing home facility.	☐
20.	Please verify the date the Applicant most recently entered the nursing home facility and verification of the dates of admittance and sequence of the facilities they were placed prior to their current nursing home stay.	☐
21.	Please provide copies of any outstanding medical bills that will not be covered by Medicare or the Applicant's supplemental health insurance.	☐
22.	Please provide a copy of the prior Medicaid Application.	☐
23.	Please provide copy of any and all correspondence with Medicaid.	☐
24.	Please provide copy of all notices sent by DDS including Notice of Denial.	☐

We will need to submit account statements that cover the entire time period from the snapshot date through the actual application date and account for all transactions during that time period. Please provide us with the statements from the snapshot date through the current date, and then continue to provide us with updated account statements through the time the application is actually filed. **We need complete statements with all pages, even if there does not appear to be any relevant information on a particular page. As we review the statements, we may need to ask you for additional clarification or documentation regarding the transactions. For checking accounts, please provide any canceled check copies that you have. If you are not already having copies of your checks included with your statements, please request this service. You may also consider establishing online access for any open accounts.

The Medicaid Agency has 90 days (from the date of receipt) in which to approve an Application. Therefore, it is essential that you provide all requested documentation promptly.