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

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

Person Completing Form (if different from the client):

Name: ______________________________
(first, middle, last)

Home Address: ______________________________

Cell phone: ______________ Home phone: ______________

Email: ______________ Work phone: ______________

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

Relationship with Incapacitated person: ______________________________

Client Information:

Full Name: ______________________________
(first, middle, last)

Date of Birth: ______________ Place of Birth: ______________

Home Address: ______________________________

Social Security Number: ______________ Email: ______________

Cell phone: ______________ Home phone: ______________

U.S. Citizen? ☐ Yes ☐ No Are you a military veteran? ☐ Yes ☐ No

Spouse Information:

☐ Current Spouse ☐ Former Spouse ☐ Neither

Spouse's Name: ______________________________
(first, middle, last)

Date of Marriage: ______________ Place of Marriage: ______________

If former spouse, provide termination year: ______________

How marriage terminated: ☐ Divorce ☐ Death ☐ Other: ______________

There are 2 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*

Information About the Client's Health

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: ____________________________

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*

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.

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 . . . . ☐
Same, but someone assists you there with above activities ☐
Apartment in retirement living community . . . . ☐
Assisted Living Facility . . . . ☐
Nursing Home . . . . ☐
Other: ____ ☐

Income

	$ per month	$ per year
Monthly Social Security Income	$	$
Monthly Retirement Income other than Social Security (IRA, 401(k), etc.)	$	$
	$	$
Monthly Investment & other income	$	$
	$	$
	$	$

Resources

The approximate value of each asset owned should appear in only one of the columns.

Assets	Sole Name	Joint Names
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