# Medicaid Planning
# Client Intake Form

**Leigh Hilton, PLLC**
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## Responsible Party:

This information is being provided by (your name here): _____

Relationship to the person(s) seeking medicaid planning: _____

Your mailing address: _____

_____

Your daytime telephone number: _____

Your email address: _____

Does the person seeking Medicaid planning have Durable
P.O.A or Guardianship? Check One: ☐ P.O.A. ☐ Guardianship ☐ Neither

Has a Health Care agent been appointed? ☐ Yes ☐ No

Has a Living Will (Directive to Physicians) been established? ☐ Yes ☐ No

Does this person(s) have a Last Will & Testament? ☐ Yes ☐ No

Revocable Trust? ☐ Yes ☐ No Irrevocable Trust? ☐ Yes ☐ No

_____ _____
Name of P.O.A. (if other than listed above) P.O.A. Phone

## Person Seeking Medicaid Planning:

Please provide information regarding the individual(s) who is seeking protection of assets from Medicaid:

Name: ☐ Mr. ☐ Mrs. _____

Mailing address: _____

_____

Date of Birth ____/____/____ Is this person a veteran, or widow of a veteran? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Widowed

Date of Admission to hospital or nursing facility, whichever was first: ____/____/____

Current care environment (check one):

☐ at home, no assistance needed ☐ at home, with home health assistance

☐ in personal care home ☐ in assisted living facility

☐ in nursing home ☐ in hospital / skilled care facility

Monthly Fixed Cost of Care: $ _____ Other monthly expenses (medicines, etc.): $_____

Home Living Expenses: $_____

Brief description of applicant's current health status:

_____

_____

_____

## Spouse:

Name: ☐Mr. ☐Mrs. _____

Mailing address: _____

_____

Date of Birth _____/_____/_____ Is this person a veteran? ☐ Yes ☐ No

Date of Admission to hospital or nursing facility, whichever was first: _____

Currently care environment (check one):

☐ at home, no assistance needed ☐ at home, with home health assistance

☐ in personal care home ☐ in assisted living facility

☐ in nursing home ☐ in hospital / skilled care facility

Monthly Fixed Cost of Care: $ _____ Other monthly expenses (medicines, etc.): $_____

Home Living Expenses: $_____

Brief description of this person's current health status:

_____

_____

_____

## Real Property (Applicant & Spouse):

| Asset | Location/ Description | Owner | Value | Amount owed |
|---|---|---|---|---|
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*examples: primary residence, rental properties, family farm, etc.

## Personal Property (Applicant & Spouse):

| Asset | Location/ Description | Owner | Current Value | Current Debt |
|---|---|---|---|---|
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*examples: vehicles, travel trailers, oil / mineral rights, livestock / poultry, personal property, pre-paid funeral, burial plot, etc.

## Debt (Applicant & Spouse):

| Type | Owner | Original Amount | Amount Owed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

*examples: credit card debt, medical bills, personal loan, auto loans, other consumer debt

## Investment and Bank Accounts:

| Type of Account | Institution | Owner | Current Balance |
|---|---|---|---|
| *(EX: Checking Account* | *Bank of America* | *Bill Jones* | *$ 13,500 )* |
| | | | |
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## Monthly Income of Applicant / Spouse:

| Source of Income | Payee | Gross Amount | Net Amount |
|---|---|---|---|
| *(EX: Social Security* | *John Smith* | *$816.90* | *$712.00)* |
| | | | |
| | | | |
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| | | | |
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| | | | |

*examples: annuity, pension, retirement distributions, employment, social security

## Insurance (Applicant & Spouse):

Life Insurance →

| Company | Death Benefit | Cash Value | Insured / Owner | Beneficiary | Monthly Premium |
|---|---|---|---|---|---|
| *(Prudential* | *$25,000* | *$8,500* | *John Smith* | *Mary Smith* | *$50 / month)* |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Long Term Care Insurance →

Long Term Care Insurance? ☐ Yes ☐ No Monthly Premium: _____

Elimination Period: _____ days Daily Benefit: _____

Maximum benefit: _____ If you are receiving LTC benefits, when did this begin? _____

Spouse Long Term Care Insurance →

Long Term Care Insurance? ☐ Yes ☐ No Monthly Premium: _____

Elimination Period: _____ days Daily Benefit: _____

Maximum benefit: _____ If you are receiving LTC benefits, when did this begin? _____

## Family Background:

CHILDREN (if applicable)

(1) Name: _____ Circle one: male/ female
(First) (Middle) (Last)

Date of Birth: _____ Circle one: his child/ her child/ joint child

Address: _____
Street City State Zip code

Phone #: _____ E-mail: _____

Is this child married? Spouse's name: _____

Does this child have children? If yes, please provide their names and ages below

_____

_____

Special Needs/Considerations for this child or their children: _____

_____

(2) Name: _____ Circle one: male/ female
(First) (Middle) (Last)

Date of Birth: _____ Circle one: his child/ her child/ joint child

Address: _____
Street City State Zip code

Phone #: _____ E-mail: _____

Is this child married? Spouse's name: _____

Does this child have children? If yes, please provide their names and ages below

_____

_____

Special Needs/Considerations for this child or their children: _____

_____

(3) Name: _____ Circle one: male/ female
(First) (Middle) (Last)

Date of Birth: _____ Circle one: his child/ her child/ joint child

Address: _____
Street City State Zip code

Phone #: _____ E-mail: _____

Is this child married? Spouse's name: _____

Does this child have children? If yes, please provide their names and ages below

_____

_____

Special Needs/Considerations for this child or their children: _____

_____

(4) Name: _____ Circle one: male/ female
(First) (Middle) (Last)

Date of Birth: _____ Circle one: his child/ her child/ joint child

Address: _____
Street City State Zip code

Phone #: _____ E-mail: _____

Is this child married? Spouse's name: _____

Does this child have children? If yes, please provide their names and ages below

_____

_____

Special Needs/Considerations for this child or their children: _____

_____

*If more children please continue on back

Do you have any children that have passed away? No☐ Yes☐

If yes, did they leave any surviving children? Yes☐ No☐

Does the client have any adult disabled children? ☐ Yes ☐ No
If so, please provide a brief description of the child's disability:

_____

_____

_____

## Other Information:

Who may we thank for referring you to Leigh Hilton, PLLC?

_____
_____

What result do you expect from the planning provided by Leigh Hilton, PLLC? (i.e., preserving the family's estate, avoiding unnecessary nursing home expenses, etc.)

_____
_____
_____

The information provided herein to Leigh Hilton, PLLC is complete and accurate. I understand that Leigh Hilton is under no obligation to further investigate and verify the accuracy of this data, and that Leigh Hilton will formulate and base its recommendations on the data provided on this form.

_____ _____

(Signature of responsible family party) Date

_____

(Print your name here)

**Please review this list and provide copies within the next 15 days of any of these documents and/or statements that apply to you. These are necessary to accurately complete your Medicaid Benefits Plan. We only need items that apply to your case. For example, if you or your spouse don't have a bank account, we do not need bank statements.**

- ☐ Social Security Card
- ☐ U.S. Passport, Birth Certificate, Certificate of Naturalization, OR Medicare Card
- ☐ Registration card OR papers form US Citizenship and Immigration Serves
- ☐ Last Will and Testaments
- ☐ Revocable/Irrevocable Trust(s)
- ☐ Financial Powers of Attorney
- ☐ Healthcare Powers of Attorney
- ☐ Guardianship Orders
- ☐ Living Wills (Directives to Physicians)
- ☐ If still employed - last 6 pay stubs or paychecks, a statement from employer OR self-employment records
- ☐ Social Security, pension, veterans benefits, Supplemental Security Income (SSI), workers' compensation, unemployment, or other government benefits – Award letter OR pay stubs (we will need your claim number for any money received from Social Security or Railroad Retirement)
- ☐ Burial Plots (deeds to cemetery property)
- ☐ Pre-paid Funeral Plans
- ☐ Bank Account statement (this month AND last 3 months)
- ☐ Stock portfolio statements (Trust bond instrument OR current statements)
- ☐ All insurance policies (health, life, Medicare supplement, long term care - policies showing the current value)

❑ Medical, dental, and private insurance costs – Bills, receipts, statements, OR canceled checks from this month and the past 3 months

❑ Real Estate property values (tax statement OR market appraisal)

❑ Real Estate Deeds showing current owner(s)

❑ Real Estate Notes (notes owed to you)

❑ Deeds showing Life Estate Interest

❑ Oil, gas mineral, surface rights owned or leased (Current tax statements, division orders, deeds, promissory or mortgage note, OR royalty statements)

❑ Child support you pay – Divorce decree, court order, or district clerk record showing how much you pay

❑ Child support you get – District clerk record. OR letter from parent who pays showing how much, how often, AND the date it is usually paid. The letter must be dated and have the name, address, phone number, and signature of the parent who pays

❑ Loans, repayments, and gifts (includes someone paying bills for you) – Loan agreement. Or statement from the person giving or repaying you money, OR paying your bills. The statement must be dated and have that person's name, address, phone number, and signature

❑ Any paperwork pertinent to any items you listed on the preceding questionnaire that has not already been requested