MEDICAID INFORMATION FORM **Date: _____**

Applicant (*****): _____

In order for us to properly assess your eligibility for Medicaid (or SSI), we must have **all** of the following information. If you do not understand any question, ask our attorney or legal assistant about it. In this form, the word "**Applicant**"(*****) refers to the person for whom Medicaid is to be sought.

1. Applicant (and Spouse if applicable)

	Applicant	Spouse
a. Full Name:	_____	_____
b. Other/Former Names:	_____	_____
c. U.S. Citizen:	Yes _____ No _____	Yes _____ No _____
d. If not citizen, legal aliens date of entry to U.S.:	_____	_____
e. Date of Birth:	_____	_____
f. Soc. Sec. No.	_____	_____
g. Residence Address:	_____	_____
	_____	_____
Phone:	_____	_____

2. Marital Information

a. Date and place of marriage: _____

b. Has Applicant ever been married before? ____ Yes ____ No [For each, complete:]

Applicant's former spouse: _____

How marriage ended: ____ death ____ divorce Date of death/divorce: _____

Applicant's former spouse: _____

How marriage ended: ____ death ____ divorce Date of death/divorce: _____

3. Applicant's Parents (if living)

	Father	Mother
a. Full Name:	_____	_____
b. Other/Former Names:	_____	_____
c. U.S. Citizen:	Yes _____ No _____	Yes _____ No _____
d. If not citizen, legal aliens date of entry to U.S.:	_____	_____
e. Date of Birth:	_____	_____
f. Residence Address:	_____	_____
	_____	_____
Phone:	_____	_____

4. Employment

a. Does **Applicant** work? Yes _____ No _____
If "Yes", employer: _____
Self-employed? Yes _____ No _____
Total wages (monthly) before deductions: $ _____ Paid how often? _____
If not employed, date and employer of last employment: _____

b. Does **Applicant's spouse** work? Yes _____ No _____
If "Yes", employer: _____
Self-employed? Yes _____ No _____
Total wages (monthly) before deductions: $ _____ Paid how often? _____
If not employed, date and employer of last employment: _____

5. Veteran Status

a. Is Applicant a veteran? Yes _____ No _____ Married to a veteran? Yes _____ No _____
b. Is Applicant a dependent of a **living** or **deceased** veteran? Yes _____ No _____
c. If answered "Yes" to any of above, complete the following:
Name of veteran: _____
Relationship to Applicant: _____
Veteran's Service No. or Claim No.: _____
Branch of Service: _____ Dates of Service: _____
d. Has Applicant ever applied for VA benefits under Veterans and Survivors Improvement Act? Yes ____ No ____
e. If Applicant in a nursing home, has Applicant ever applied for VA Aid & Attendance benefits? Yes ____ No ____

6. Physical/Mental Condition(s) (Diagnosis and Description)

a. Applicant: _____
_____
b. Spouse: _____
_____
c. What prescription medicines do you take?
Applicant: _____
_____
Spouse: _____
_____

7. Abilities and Disabilities

a. Are you able to sign your name without assistance?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
b. Are you able to sign your name with assistance?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
c. Are you able to read and understand what you read?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
d. Do you have trouble remembering friends, family members and events from long ago?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
e. Do you have trouble remembering things that happened recently?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

f. Do you have difficulty hearing?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

g. Do you have difficulty seeing?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

h. Do you require assistance with any of the following activities on a daily basis?
Eating: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Drinking: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Walking: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Bathing: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Toileting: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Dressing: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

i. Are you able to keep your own checkbook and financial records without assistance?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

j. Do you generally know what assets (money, land, etc.) you own and what debts you owe?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

k. Have you given anyone a written **power of attorney**? (If "yes" give name & address)
Applicant: Yes _____ No _____ To: _____
Agent's address: _____
Spouse: Yes _____ No _____ To: _____
Agent's address: _____

l. Does Applicant have a court-appointed **guardian or conservator**? Yes _____ No _____
Name: _____
Address: _____

m. Is Applicant the **beneficiary of a trust**? Yes _____ No _____
Trustee's name: _____
Address: _____

8. Physician(s)

Applicant #1: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____
Applicant #2: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Spouse #1: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____
Spouse #2: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

9. Applicant's Household Members

a. List members of Applicant's household. If Applicant in nursing facility, list people living in house prior to Applicant entering nursing facility:

Name	Age	Relationship to Applicant

_____
_____
_____
_____
_____

b. Is any **member of Applicant's family disabled**? Yes _____ No _____ If so:
Name/Age/Relationship to Applicant: _____
_____

10. Residence Details

a. Residence **owned** by Applicant? Yes _____ No _____ (**If "No", skip to # 11**.)
b. Type residence: Single family _____ Duplex _____ Other (# units) _____
c. How owned: Sole owner _____ Joint with spouse _____ Joint with others _____ Life Estate _____
d. Date purchased: _____ Purchase Price: $_____ Estimated market value: $_____
e. First mortgage (lender): _____
Balance owed: $ _____ Monthly payments: $_____
Second mortgage (lender): _____
Balance owed: $ _____ Monthly payments: $_____
f. Has a child lived in the residence with Applicant for at least 2 years? Yes _____ No _____
If so, has the child provided personal care and assistance to Applicant that might have kept Applicant out of nursing facility? Yes _____ No _____
Describe assistance: _____
g. If other owner is a sibling, has that sibling lived in the residence for at least one year?
Yes _____ No _____
Does that sibling have an equity interest in the home? Yes _____ No _____
h. Reverse Mortgage on property? Yes _____ No _____

11. Residence Rented

a. Residence rented? Yes _____ No _____ Monthly cost: $_____
b. Type of rental:
____ Single family house ____ Retirement Community ____ Assisted Living
____ Apartment ____ Senior Housing (Subsidized? Yes ____ No ____)

12. Long Term Care (Nursing Home)

a. Is Applicant or spouse in a nursing home?
Applicant: Yes ____ No ____ Spouse: Yes ____ No ____
b. If so, date of entry (continuous stay since entry): _____
c. Name of nursing facility: _____
Address: _____
Phone: _____
Administrator /contact person: _____
d. Does the facility accept Medicaid? Yes _____ No _____

13. Hospitalization(s)

a. Is Applicant or spouse in a hospital?

Applicant: Yes _____ No _____ Admission Date: ________________________________

Hospital name/address: ____

Spouse: Yes ______ No ______ Admission Date: ________________________________

Hospital name/address: ____

If so, for how long? ____

Reason for admission: ____

Convalescence in nursing home expected? Yes ______ No ______

If nursing home placement is expected, likely to later return home? Yes ______ No ______

b. Hospital admissions during last 3 years (hospital name / dates / reason):

Applicant: ____

____

Spouse: ____

____

14. Health and LTC Insurance

a. Does Applicant have **Medicare Part A**? Yes ____ No ____ **Part B**? Yes ____ No ____

Medicare Claim No.: ____

b. Does Applicant have **other health insurance** of any type? Yes ____ No ____

Company name: ____

Address: ____

Policy No.: ____________________________ Begin date: ___________ End date: _____________

Policy owner: __________________________ Relation to Applicant: ________________________

Type policy: Cancer _____ Medicare Supplement _____ Hospital Indemnity _____

Accident _____ Intensive Care _____ Long Term Care ______

Other (explain) ____

Company name: ____

Address: ____

Policy No.: ____________________________ Begin date: ___________ End date: _____________

Policy owner: __________________________ Relation to Applicant: ________________________

Type policy: Cancer _____ Medicare Supplement _____ Hospital Indemnity _____

Accident _____ Intensive Care _____ Long Term Care ______

Other (explain) ____

Company name: ____

Address: ____

Policy No.: ____________________________ Begin date: ___________ End date: _____________

Policy owner: __________________________ Relation to Applicant: ________________________

Type policy: Cancer _____ Medicare Supplement _____ Hospital Indemnity _____

Accident _____ Intensive Care _____ Long Term Care ______

Other (explain) ____

15. Income

a. Monthly Income

Source (describe):	Whose "Name on Check" (Applicant)	(Spouse)	Terminate @ death? Y / N
Social Security _____	$_____	$_____	_____
SSI _____	$_____	$_____	_____
Railroad Retirement _____	$_____	$_____	_____
State Retirement _____	$_____	$_____	_____
Private Retirement (IRA, etc.) _____	$_____	$_____	_____
Pension (_____)	$_____	$_____	_____
Rental Income (_____)	$_____	$_____	_____
Interest Income (_____)	$_____	$_____	_____
Alimony (_____)	$_____	$_____	_____
Child Support (_____)	$_____	$_____	_____
Other (_____)	$_____	$_____	_____
Totals:	$_____	$_____	

b. Did Applicant or Spouse file income tax return last year:
Federal: Yes _____ No _____ State: Yes _____ No _____

16. Financial Information

Please supply information pertaining to real property, bank and savings accounts, retirement plans, insurance and annuity policies, personal property, liabilities, income and expenses on the separate **FINANCIAL INFORMATION** schedule.

17. Other Property Interests (Liberalized Rules)

a. Does Applicant own the following? (indicate **Applicant**, **Spouse** or **Both** and describe):
(i) Life estate in any property? _____
(ii) Remainder interest in property? _____
(iii) Undivided heir interest in property? _____
(iv) 16th Section leasehold? _____
(v) Mineral or timber rights not in production? _____
(vi) Income producing property? _____
(vii) Promissory notes from others? _____
(viii) Automobiles? (give Make/Model/Year/Value) _____
_____
(ix) Personal property up to $5,000 equity value? _____
(x) Cash value life insurance policies? _____
(xi) Assets essential for self-support? _____

b. Does Applicant or Spouse own **burial spaces** for family members? Yes _____ No _____
Name & location of cemetery: _____ No. gravesites owned: _____
All spaces for Applicant's family? Yes _____ No _____

c. Are **burial funds** set aside? **Applicant**: Yes ____ No ____ **Spouse**: Yes ____ No ____
How are funds set up? Cash ____ Burial contract or insurance ____ Other _____
Value or Amount of funds: Applicant $ _____ Spouse $ _____
Can funds be cashed in? **Applicant**: Yes ____ No ____ **Spouse**: Yes ____ No ____

18. Gifts

a. Has Applicant made any gifts of money or property during last five years? Yes _____ No _____

b. Applicant made any transfers to or from a trust within the last five years? Yes _____ No _____

c. Details:

Recipient	Amount/Type Property	Date of Gift

d. Gift tax returns filed? Yes ____ No ____ If so, what years? _____

19. Most Trusted Child(ren)

a. Does Applicant or Spouse rely on one or more children for financial or personal assistance?
Yes _____ No _____ If so, who has assistance responsibilities?
(i) For Applicant: _____
(ii) For Spouse:_____

20. Problem Family Members

a. Is any family member not to be relied upon to help with management or other need of Applicant or Spouse? Yes _____ No _____

b. If so, name & relationship to Applicant:_____
_____

c. Why?_____
_____

21. Person(s) supplying answers to these questions:

a. Name _____

b. If not Applicant, relationship to Applicant: _____

NOTES:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAID PLANNING DOCUMENTS AND INFORMATION NEEDED

Medicaid Applicant: _____

Applicant's Spouse: _____

NOTE: In applying for Medicaid or planning for Medicaid (or SSI) eligibility, proper documentation is essential. Medicaid will often require copies of the documents listed in this request as part of an application. The word "**Applicant**" in this form means the person for whom Medicaid will be sought. Please give us the original (or a copy if the original is unavailable) of **each** of the following documents, for **both** the Applicant and his/her spouse:

_____ Current Will and/or Living Trust _____ Current General Power of Attorney

_____ Current Health Care Directive, Health Care Power of Attorney or "Living Will"

_____ Deeds to all real property, including residence

_____ Most recent property tax statements (showing parcel numbers) from Tax Collector

_____ Title Certificate on any vehicle _____ Leases on any rental property

_____ Checking account statements for last one (1) months (all accounts)

_____ Brokerage and savings account statements for last one (1) months (all accounts)

_____ All documents showing source and amount of income received

_____ Copies of all bank CD's _____ Stock Certificates, Savings bonds, etc.

_____ Medical and Health insurance policies (Medicare Supplement, Long-term Care, Cancer, etc.)

_____ Life Insurance policies _____ Annuity contracts or agreements

_____ Pension and/or profit-sharing plans _____ IRA agreements

_____ Buy/Sell agreements or other agreements concerning business interests

_____ Divorce decrees, if any _____ Prenuptial or other marital agreements

_____ Prepaid burial deeds _____ Prepaid funeral policies or plans

The following are needed only if we are **to file a Medicaid Application** for you:

_____ Driver's license _____ Medicare card _____ Birth Certificate

_____ Marriage License _____ Military service records, including discharge documents

_____ Canceled checks for last three (3) months (**all accounts**)

_____ Last two (2) years federal income tax returns _____ Prior gift tax returns, if any

_____ Checking account statements for last three (3) months (**all accounts**)

_____ Brokerage and savings account statements for last three (3) months (**all accounts**)

_____ Other: _____