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The following is a list of materials needed in your first Medicaid planning appointment.

1. Current Power of Attorney document;

2. Your most current will;

3. Deed(s) to any real estate you own;

4. The current value of any checking and/or savings accounts you own;

5. The current value of any stock and/or bonds you own;

6. Any insurance policies you own; and

7. Documentation showing the current gross monthly income you receive.

Date: _____

Client Information Sheet
Single Person

Please complete this form prior to your initial meeting to allow us to more efficiently serve your needs. This form is intended to be completed by single individual. Please use the back of the form if additional space is needed.

Personal Information:

A. Client's Name: _____
First Middle Initial Last

Age:_____ Date of Birth: _____ Widow/Widower: Yes No
If so, date of death: _____

Last grade completed: _____

Have you ever been convicted of a felony? Yes _____ No_____

U. S. Citizen: Yes _____ No_____

Have you or your deceased spouse served in the military on active duty during a wartime period? Y N

Social Security No.: _____ County of domicile: _____

Street (Road) address: _____

Post Office Box (if applicable): _____

City, State & Zip: _____

Telephone No.: Home: _____ Work: _____

E-Mail Address: _____

Has anyone lived with client or has client lived with anyone during the last two years? Y N

If yes, please explain the circumstances: _____
_____
_____
_____

Please list all places where client has lived in the last two years: _____
_____
_____
_____

Is client currently in a nursing home? Yes _____ No_____

If so, name of the facility: _____

Was admission from home or from a hospital or other facility? _____

Please provide the first date of admission, name of facility, and the date of each subsequent transfer through the present:_____
_____
_____
_____

Have you, your former spouse, or anyone in your family filed for Medicaid, Food Stamps, or TANF? Yes _____ No_____

B. Contact Person/POA: _____
First Middle Initial Last
Street (Road) address: _____

Post Office Box (if applicable): _____

City, State & Zip: _____

Telephone No.: Home: _____ Work: _____

E-Mail Address: _____

C. Names and addresses of each of your children:

Name (first, middle initial, last):	Address/Phone:	D.O.B.
1. _____	_____	_____
	_____	
2. _____	_____	_____
	_____	

(next page for additional children)

3. _____ _____ _____

_____

4. _____ _____ _____

_____

5. _____ _____ _____

_____

6. _____ _____ _____

_____

Do any of your children receive Social Security Disability benefits? _____

Loans:

Does anyone presently owe you any money (or other debt)? Y N

If yes, do you have written documentation signed by the debtor? Y N

Please list the amount owed to you for each loan and payment terms: _____

_____

_____

Monthly Income:

Social Security _____

Pension _____

Annuity _____

Other _____

_____

Total _____

Income Taxes:

Are you required to file a federal income tax return? Y N

Do you claim any dependents? Y N

Are you claimed as a dependent on another person's taxes? Y N

Expenses:

Supplemental Health Insurance:
Monthly premium: _____ Company Name:_____

Do you have Medicare Part C Coverage?_____
Medicare Part D (Prescription) Coverage:

Monthly premium: _____ Company Name:_____

Monthly Utilities: _____

Monthly House payment or rent payment: _____

Annual Real Estate Taxes: _____

Annual Property Insurance: _____

Assets:

Do you own a qualified annuity (funded with retirement funds)? Y N

Do you own a non-qualified annuity (not funded with retirement funds)? Y N

Real Estate:

Address:_____

Acreage: _____

Please provide a copy of the most current deed(s) and real estate tax bill(s).

Vehicle(s): _____

Bank Accounts (please add additional pages as necessary):

Name of Bank: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____
Type of Account/Account Number: _____
Current Balance: _____

Name of Bank: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____

Other Investments:

Name of Company: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____

Name of Company: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____

Type of Account/Account Number: _____
Current Balance: _____

Life Insurance (please add additional pages as necessary):

Company: _____

Policy Number: _____ Value: _____

Company: _____

Policy Number: _____ Value: _____

Company: _____

Policy Number: _____ Value: _____

Nursing Home Insurance:

Company: _____

Policy Number: _____ Elimination Period: _____

Daily or Monthly Benefit: _____

Benefit Length: _____

Other Assets: _____

Do you own cemetery lots? Yes _____ No _____
If yes, please provide a copy of the deed for such lot(s).

Do you own prepaid funeral arrangements? Yes _____ No _____
If yes, please provide us with <u>all</u> documents pertaining to such arrangements.

Gifts:

Please list all gifts made within the last five years (no matter how small or for what reason—excluding gifts to charities and churches). Please use a separate sheet of paper if necessary.

Date	Amount	Recipient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral:

Who referred you to this office?

Name _____

Street Address _____

City _____ State _____ ZIP _____

_____
Client's Signature

Date: _____

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