DALE, HUFFMAN & BABCOCK LAWYERS

Medicaid Client Intake Form

Client Name: _____ Prefer to be called: _____

Birth date: _____ Social Security #_____-_____-_____ US Citizen? Yes No

Home Address: _____ City: _____

State: _____ Zip Code: _____ Primary Contact Number: _____

County of Residence: _____ Employer: _____

E-mail Address: _____ ❑ *It is okay to communicate with me via my e-mail address.*

How did you hear about our law firm? _____

Marital Status (please select one): Single Married Divorced Widowed

Date of Marriage (if married to 2nd client) _____

Is this your 1st Marriage Y N 2nd Marriage Y N

Are you a Veteran? Y N

Last grade of education completed: _____

2nd Client's Name: _____ Prefer to be called: _____
(Spouse/Partner/Companion)

Birth date: _____ Social Security #_____-_____-_____ US Citizen? Yes No

Home Address: _____ City: _____

State: _____ Zip Code: _____ Primary Contact Number: _____

County of Residence: _____ Employer: _____

E-mail Address: _____ ❑ *It is okay to communicate with me via my e-mail address.*

Marital Status (please select one): Single Married Divorced Widowed

Date of Marriage (if married to 2nd client) _____

Is this your 1st Marriage Y N 2nd Marriage Y N

Are you a Veteran? Y N

Last grade of education completed: _____

Monthly Income

	Client	2nd Client
Social Security		
Pension		
Annuity		
Other:		
Other:		
Other		
Total		

Taxes

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

Do you file jointly? Y N

Do you claim any dependents (other than your spouse)? Y N

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

Miscellaneous Information

Is either client receiving SSI, SSD, disability, or other governmental benefits? Y N
If so, please describe: _____

_____

_____

_____

If married, have the clients signed a pre- or post-marital agreement or contract? Y N
If so, please provide a copy.

Has either client ever filed federal gift tax returns? Y N
If so, please provide a copy or copies of such return(s).

Has anyone lived with either client or has either client lived with anyone else during the last two (2) years? Y N
If so, please explain the circumstances: _____
_____
_____
_____

Please list all the places where either client has lived in the last two (2) years: _____
_____
_____

Has either client been admitted into a hospital and/or nursing home facility for 30 or more consecutive days? Y N

Is either client currently in a nursing home, assisted living or rehabilitation center? Y N
If so, please complete the following:

Name of facility:_____

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

Please provide the following information starting with the first date of admission up to present:

1st Date of Admission	Name of Facility	Date of Transfer

Please list any charitable organizations to which you are considering making gifts in your estate planning document: _____
_____
_____
_____

Do you own any Real Estate outside of Indiana? If so, please provide additional information:
_____
_____
_____

Is either client currently the beneficiary of anyone else's trust, expect an inheritance in the future, or expect a large lump sum payment of money in the future (such as a lawsuit settlement)? Y N
If so, please explain*:* _____
_____
_____

Do any of your intended beneficiaries have special educational, medical, or physical needs? Y N

If so, please explain: _____

_____

_____

_____

Do you provide major financial support to adult children or other beneficiaries that is considered to be an advancement, or part of their estate inheritance? Y N

If so, please explain: _____

_____

_____

Have you made any gifts, transfers, or loans to adult children within the last five years that exceeds $1,200 total? Y N If so, please explain:_____

_____

_____

_____

Children

Parent: (child belongs to) 1st client, 2nd client, both	Child's Legal Name	Birth Date	Marital status (S/M/D/W)	Address
1st 2nd Both				
1st 2nd Both				
1st 2nd Both				
1st 2nd Both				
1st 2nd Both				
1st 2nd Both				

If there are any additional children, please list them on the reverse side or on an attached sheet

Do any of your children receive SSI, Social Security Disability or Medicaid benefits? Y N

Please provide date of death and age at death for any children, including if the deceased has any descendants: _____

_____

_____

Professional Advisors

Role	Name	Telephone
Accountant		
Financial Advisor		

Real Property

General Description and/or Address	Owner	Est. Market Value	Loan Balance

Motor Vehicles and Watercraft

For each motor vehicle, boat, RV, etc., please list the following:

Description	Titled	Est. Market Value	Loan Amount

Bank Accounts

For all funds not in a retirement account, under "Type" please indicate as follows: Checking Account "CA", Savings Account "SA", Certificate of Deposit "CD", Money Market "MM"

Name of Institution	Account Number	Type	Owner	Amount

Stocks and Bonds

For all funds not in a retirement account, please list any and all stocks and bonds you own. If held in a brokerage account, lump them together under each account:

Stock/Bond/Investment Account	Account Number	Type	Owner	Amount

Life Insurance Policies

Name of Institution	Account Number	Type	Owner	Death Benefit	Cash Surrender Value

Annuities

Name of Institution	Account Number	Annuitant	Monthly Benefit	Qualified?	Death Benefit

Retirement Plans

Under "Type" please indicate as follows: Pension (P), Profit Sharing (PS), IRA, SEP, 401(K), 403(B). Please also indicate whether any accounts are "Roth" type accounts:

Name of Institution	Account Number	Type	Owner	Current Balance

Business Interests

Please indicate type of interest, such as: general and limited partnerships, sole proprietorships, privately owned corporations, professional corporations, S-corporations, LLCs, LLPs, oil interests, farm and ranch interests. Please also provide a description of the interests, who has the interest, your percentage ownership in the businesses, and the estimated value of the interests:

_____

_____

_____

Money Owed to You

Name of Debtor	Date of Note	Maturity Date	Owed To	Current Balance

Other Assets and Debts

Description	Owner	Value

Please include any additional relevant information, questions, or concerns: _____
_____
_____
_____

****

By signing below, I/we understand that the information I/we provide when completing this questionnaire will be used in providing estate planning, asset protection, Medicaid planning advice and/or other legal services, and that it is my/our responsibility to ensure the accuracy and completeness of such information.

_____ _____
Client Signature Date

_____
1st Client Printed Name

_____ _____
2nd Client Signature Date
(Spouse/Partner/Companion)

_____
2nd Client Printed Name