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ASSET PROTECTION QUESTIONNAIRE

Date _____ Home Phone No. _____ Business Phone No. _____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to the appointment.

A. PERSONAL DATA

Full Name _____

Street Address _____

City _____ State _____ Zip _____

Birth Date _____

Social Security No. _____

U.S. Citizen? Yes No

Veteran? Yes No

B. MEDICAL DATA

1. HEALTH

Diagnosis _____

Prognosis _____

Course of Treatment _____

Please indicate the name of the nursing home and the date first entered on a continuous basis

2. PHYSICIAN

Full Name of Primary Physician _____

Street Address _____

City _____ State _____ Zip _____

3. **HEALTH INSURANCE**

Do you have a Medicare Supplement Health Policy? Yes No

If Yes, attach policy of summary of benefits

Do you have Long Term Care Insurance? Yes No

If Yes, attach policy or summary page of benefits

C. **MONTHLY INCOME** (Do not include interest and dividend income)

	Monthly Income
Social Security Benefits (include \$54.00 Medicare Part B Deduction, if applicable)	\$ _____
Retirement Benefits (Gross)	\$ _____
VA Disability Benefit	\$ _____
Annuity Income	\$ _____
Rental Income	\$ _____
Other Income (Please list)	\$ _____

TOTAL MONTHLY INCOME \$ _____

If there is a pension, please list the *gross pension amount*, including any monies taken out for federal income taxes, health insurance, or any other reason.

Could this pension amount increase in the future? Yes No

Is there any possibility of the Medicaid applicant receiving an inheritance? Yes No

If Yes, from whom and approximate amount. _____

D. **MONTHLY COST OF NURSING HOME** (If currently residing in nursing home, if not residing in the nursing home, proceed to Part E..)

\$ _____	Monthly Nursing Home Cost
\$ _____	Monthly Prescription Cost
\$ _____	Monthly Incontinent Cost
\$ _____	Monthly Other Cost
\$ _____	Total Monthly Costs

The nursing home is paid through _____ (month/year).

**E. MONTHLY SHELTER EXPENSES (If not currently residing in nursing home)
(Please divide annual expenses by 12 and quarterly expenses by 3)**

\$ _____	Rent/Mortgage
\$ _____	Real Estate Taxes
\$ _____	Water
\$ _____	Sewer
\$ _____	Utilities (Heat, Electric & Telephone) (1/12th of last 12 months)
\$ _____	Homeowner=s insurance premium
\$ _____	Condominium fees
\$ _____	Total Monthly Housing Expenses

F. MONTHLY NON-SHELTER LIVING EXPENSES (If not living in the nursing home)

\$ _____	Food
\$ _____	Medical
\$ _____	Clothing
\$ _____	Transportation (including auto insurance)
\$ _____	Home Maintenance
\$ _____	Life Insurance Premiums
\$ _____	Health Insurance Premiums
\$ _____	Cable TV
\$ _____	Federal and State Income Taxes
\$ _____	Life Insurance Premiums
\$ _____	Alimony
\$ _____	Child Support
\$ _____	Other
\$ _____	Total Monthly Non-Shelter Living Expenses

G. ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space. (Attach separate sheets if necessary)

Asset	Fair Market Value	How is the asset owned? Joint tenants (jt), tenants in common (tc), single owner (S)	List all name(s) on the account	LIABILITIES
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE)				
OTHER REAL ESTATE				
ADDITIONAL AUTOMOBILES				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

Address of Personal Residence:

Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

Assessed Value: \$ _____ Attached copy of last tax statement.

What did you pay for this property including any improvements? \$ _____

Is anyone currently residing in personal residence? Yes No

When was personal residence purchased? _____

Has the current owner used and occupied the home for the past 2 years? Yes No

Address of any real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____

(2) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____

Attach copies of deeds for all real property.

Do you have an irrevocable burial plan? Yes No

If yes, attach copy of plan.

H. GIFTS

Please list all gifts made in the last 3 months. Please list all gifts in excess of \$3,000 in any one month, to an individual or group of individuals, within the past 36 months (attach separate sheet if necessary):

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

Have you ever filed a Federal Gift Tax Return? Yes No

If Yes, please attach copies.

CHILDREN (if applicable)

CHILD'S NAME	ADDRESS (WITH ZIP CODE)	TELEPHONE NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Are all the children from the same marriage? Yes No

If No, Please explain _____

Are all the children in good health? Yes No

Are any of the children blind? Yes No

Are any of the children disabled? Yes No

Are any of the children receiving SSI or other form of government entitlement? Yes No

Do any of the family members have any problems with:

AIDS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drug Addiction?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Alcoholism?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Spendthrift?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marital Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please provide details if you answered yes to any of the above questions. _____

Has any family member live with you in your home? Yes No

If yes, name of family member, and how long has the family member lived in home? _____

K. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes No

If yes, please explain _____

ATTACHMENTS

Please attach copies of the following documents to this form

1. Deeds to all real property.

2. Annuity Contracts
3. Long Term Care Policies
4. Disability Policies
5. Last Property Tax Assessment
6. Estate Planning Documents including, Last Will and Testament, Revocable Living Trust, Living Will, Irrevocable Trust Agreements, Financial Durable Power of Attorney, Medical Durable Power of Attorney.
7. Last 2 year income tax returns
8. Life Insurance Policies with latest statement from the Insurance Company regarding cash value and death benefit.
9. Latest account statements received for investments itemized under Part G.
10. Divorce or Separate Maintenance Decree.

L. REFERRAL

By Whom Were You Referred To This Office?

Name _____

Street Address _____

City _____ State _____ Zip _____

M. CERTIFICATION

The undersigned hereby represents to the LAW OFFICES OF BRADLEY J. FRIGON, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:
