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MEDICAID INTAKE FORM (MARRIED)

Your name: _____ Client Name: _____

Name of person requesting Medicaid : _____

PERSONAL DATA – PRIMARY CONTACT

- Name of Spouse Living at Home (Well Spouse):** _____
 DOB: _____ SSN: ____-____-____ County: _____
 Street Address: _____
 City, State, Zip: _____
 Day Phone: _____ Eve. Phone: _____ Cell Phone: _____
 Email Address: _____
 Employer: _____ Retirement Date: _____ Veteran ___ Y ___ N

Other Spouse (Medical Applicant): _____
 DOB: _____ SSN: ____-____-____
 Employer: _____ Retirement Date: _____ Veteran ___ Y ___ N

- If spouse is currently in health care facility:**
 Name of Facility: _____
 Address: _____
 Type of facility: _____ Level of care: _____ Date of Admission _____
 If spouse entered this facility from *another* health care facility, date of his/her admission to the *initial* facility: _____
 Mental Health Status: _____
 Physical Health Status: _____
 Current source of payments for spouse’s care: _____
 Is the Facility Medicaid Certified? _____

FAMILY

3. Name(s) of child(ren):

Name: _____ DOB: _____ Marital Status: _____
Address: _____
Day Phone: _____ Eve. Phone: _____
Email Address: _____

Name: _____ DOB: _____ Marital Status: _____
Address: _____
Day Phone: _____ Eve. Phone: _____
Email Address: _____

Name: _____ DOB: _____ Marital Status: _____
Address: _____
Day Phone: _____ Eve. Phone: _____
Email Address: _____

Name: _____ DOB: _____ Marital Status: _____
Address: _____
Day Phone: _____ Eve. Phone: _____
Email Address: _____

List any special medical, educational, or other extraordinary personal or financial needs
of any of the children _____

Do you have any disabled child(ren): _____ Y ___ N
If so, please provide a description of their needs: _____

**Do any of your children have marital problems, creditor problems, drugs or alcohol
problems?:** _____ Y ___ N
If so, please provide a description: _____

Do you have any predeceased children? _____Y _____ N
 If so, please provide date of death and list any surviving children of predeceased child:

4. **Is anyone (other than your spouse) dependent upon the client for support? If so, please identify the person, and provide some general information as to the reason for, and extent of, supported provided:** _____

5. **Has a child been living in your home with you and providing caretaking services? If so, please provide dates and services provided:** _____

LIVING ARRANGEMENTS

What is your current living arrangement?	Husband	Wife
Renting a Home	_____	_____
Own/Buying a Home	_____	_____
Nursing Home/Facility	_____	_____
Living w/Relatives	_____	_____
Living w/Friends	_____	_____
Subsidized Housing	_____	_____
Family Member Living with you	_____	_____

PROPERTY

List yours and your spouse’s property with estimated fair market values in the broad categories provided. Specify how the property is held: “H” if owned by husband alone, “W” if owned by wife alone, and “JT” if owned jointly by both spouses. **Please attach a copy of all deeds.**

<u>Family Residence</u>	Value	Ownership
Tax assessed value:	_____	_____
Mortgage Balance:	_____	_____
Type of Mortgage (i.e., reverse?)	_____	_____
Year of Purchase:	_____	_____
Purchase Price:	_____	_____

Other Real Estate

Location: _____

Tax assessed value: _____

Mortgage Balance: _____
Year of Purchase: _____
Purchase Price: _____

AUTOMOBILE(S)

#1 Year: _____
Make: _____
Model: _____
Loan Balance: _____

#2 Year: _____
Make: _____
Model: _____
Loan Balance: _____

HOUSEHOLD MEMBER INFORMATION (list anyone else who lives in your household)

Name: _____ Relationship to You: _____

Name: _____ Relationship to You: _____

Name: _____ Relationship to You: _____

Name: _____ Relationship to You: _____

Do any have a conviction for a felony that involved the possession, use or distribution of a controlled substance? Yes No

A veteran or spouse of a veteran Yes No

HEALTH INSURANCE

Husband

Do you have Medicare benefits? Yes No
If yes, Part A? _____ Part B? _____

Policy Number _____

Effective Date: Part A? _____ Part B? _____

Do you have a Medicare Supplement Health Policy? Yes No
If yes, name and address of company: _____

Do you have Long Term Care Insurance? Yes No
If yes, attach policy or benefit summary page

Do you have Veteran's Benefits health insurance? Yes No

If yes, type/amount of benefits: _____

Branch of Service: _____ Vet's Serial Number: _____

Service Entry Date: _____ Discharge Date: _____

****Attach discharge papers.**

Wife

Do you have Medicare benefits? Yes No

If yes, Part A? _____ Part B? _____

Policy Number _____

Effective Date: Part A? _____ Part B? _____

Do you have a Medicare Supplement Health Policy? Yes No

If yes, name and address of company: _____

Do you have Long Term Care Insurance? Yes No

If yes, attach policy or benefit summary page

Are you a Veteran or spouse of a Veteran? Yes No

Branch of Service: _____ Vet's Serial Number: _____

Service Entry Date: _____ Discharge Date: _____

****Attach discharge papers.**

MEDICAL DATA (for spouse requesting Medicaid)

A. Health

Diagnosis: _____

Prognosis: _____

Course of Treatment: _____

Has a medical provider told anyone in your household to cut back or limit activities in any way? If yes, explain: _____

B. Physician

Primary Care Physician _____
 Street Address _____
 City _____ State _____ Zip _____
 Phone Number _____ Fax Number _____

FINANCIAL INFORMATION

A. Monthly Income

	<u>Husband</u>	<u>Wife</u>	Other Household <u>Member</u>
Social Security Benefits	\$ _____	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____	\$ _____
Interest Income	\$ _____	\$ _____	\$ _____
Dividend Income	\$ _____	\$ _____	\$ _____
Royalty Income	\$ _____	\$ _____	\$ _____
IRA Distributions	\$ _____	\$ _____	\$ _____
Other Investment Income	\$ _____	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____	\$ _____
Earned Wages	\$ _____	\$ _____	\$ _____
Self-employed earnings	\$ _____	\$ _____	\$ _____
Reverse Mortgage Payment	\$ _____	\$ _____	\$ _____
In-kind (services vs. rent)	\$ _____	\$ _____	\$ _____
Other Income (Please list)	\$ _____	\$ _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____	\$ _____	\$ _____

If there is a pension, please list the *gross pension amount* (the dollar amount prior to federal income taxes, health insurance, or any other deductions).

Will the spouse receive a survivor's benefit? Yes No

Could this pension amount increase in the future? Yes No

B. Monthly Facility Expenses (if applicable)

\$_____ Monthly Facility Expense

\$_____ Monthly Prescription Expenses

\$_____ Monthly Utility Expenses (telephone, cable TV, etc)

\$_____ Monthly Other Expenses (list: _____)

\$_____ **TOTAL MONTHLY FACILITY EXPENSES**

The facility is currently paid through _____ (month/year).

C. Monthly Shelter Expenses (well spouse)

(To determine monthly expenses, divide annual expenses by 12 and quarterly expenses by 3)

\$_____ Rent/Mortgage

\$_____ Real Estate Taxes

\$_____ Water

\$_____ Sewer

\$_____ Utilities (Heat, Electric & Telephone)

\$_____ Home Maintenance

\$_____ Cable TV

\$_____ Homeowner's insurance premium

\$_____ Condominium fees

\$_____ **TOTAL MONTHLY SHELTER EXPENSES**

D. Monthly Non-Shelter Living Expenses

\$_____ Food

\$_____ Medical

\$_____ Clothing

LIFE INSURANCE * (attach copies of last statement)***

Name of Insured Person: _____

Name of Policy Owner: _____

Type of Insurance: _____ Policy #: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Date Purchased: _____

Face Value: _____ Cash Surrender Value: _____

Have you borrowed on the above life insurance policy? Yes No Has any money been added to the account within the past 24 mos. Yes No Have you or anyone in your household received a lump sum
payment such as a lawsuit settlement, insurance settlement, etc. Yes No **ANNUITY CONTRACT(S)**

Name of Annuitant: _____ Policy #: _____

Name of Policy Owner: _____ Name of Annuity Co. _____

Name(s) of Beneficiaries: _____

Address of Annuity Company: _____

Date Purchased: _____ Amount of Initial Premium: _____

Current Value: _____ Death Benefit: _____

BURIAL ARRANGEMENTS * (attach copies of contract or services that will be provided)***Do you have a cemetery deed? Yes No Do you have a funeral home contract? Yes No Do you have an insurance company contract? Yes No Is a bank or any other person holding money for you to be
used for funeral expenses? Yes No

MISCELLANEOUS

- A. Have you and your spouse made a will, signed a trust, powers of attorney, or other estate planning documents? Yes No
- B. Do you or your spouse anticipate receiving an inheritance? Yes No
Approximate size? _____
- C. Are you or your spouse a trust beneficiary? Yes No

ASSETS

Please attach a financial statement form or complete the following worksheet. Please list the value of the following assets owned by you, your spouse, or jointly. It is not necessary to provide the exact value of each asset; an approximation or average balance is sufficient. If you have any questions about the information requested below, please feel free to make a note and I will discuss it with you in detail when we meet.

	HUSBAND	WIFE	JOINT
Cash	_____	_____	_____
Checking Accounts	_____	_____	_____
Savings Accounts	_____	_____	_____
CDs	_____	_____	_____
Money Market Funds	_____	_____	_____
Stocks & Stock Funds	_____	_____	_____
Retirement Funds	_____	_____	_____
401(k) Plans	_____	_____	_____
IRAs	_____	_____	_____
Annuities	_____	_____	_____
Mutual Funds	_____	_____	_____
Primary Residence	_____	_____	_____
Secondary Residence	_____	_____	_____
Other Real Estate	_____	_____	_____

Copyrights, Royalties, Patents, Trademarks, and other Tangible Rights	_____	_____	_____
Life Insurance-Death Value	_____	_____	_____
Life Insurance-Cash Value	_____	_____	_____
Motor Vehicles	_____	_____	_____
Boats	_____	_____	_____
Loans to family members	_____	_____	_____
Sports and Hobby Equipment	_____	_____	_____
Household Possessions (Antiques, artwork, jewelry, collections, etc.)	_____	_____	_____
Interests in Trusts	_____	_____	_____
Family Business	_____	_____	_____
Other Business Interests	_____	_____	_____
Safe Deposit Box	_____	_____	_____
Contract of Sale	_____	_____	_____
Income Tax Refund	_____	_____	_____
Other	_____	_____	_____
TOTAL ASSETS	_____	_____	_____
 LIABILITIES			
Real Estate Mortgage	_____	_____	_____
Auto Loans	_____	_____	_____
Business Loans	_____	_____	_____
Reverse Mortgage	_____	_____	_____
Other Long-term Debt	_____	_____	_____
Credit Card Debt	_____	_____	_____
Personal Loans	_____	_____	_____

Other Short-term Debt	_____	_____	_____
TOTAL LIABILITIES	_____	_____	_____

***YOU MUST ATTACH THE LAST SIX ACCOUNT STATEMENTS FOR EACH BANK, INVESTMENT, RETIREMENT OR LIFE INSURANCE ACCOUNT AND COPIES OF DEEDS TO YOUR REAL PROPERTY**

***PLEASE ATTACH COPIES OF TRUSTS, WILLS, AND POWERS OF ATTORNEY.**

From what sources did you hear about our Law Offices? _____

I hereby represent to The Law Offices of Bradley J. Frigon that the information contained in this intake form is accurate and complete, and I understand the law firm 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.

Dated: _____.

Name of person who prepared this form

Signature