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MEDICAID INTAKE FORM
(MARRIED)

Your name: ______________________________ Client Name: _____________________________

Name of person requesting Medicaid : ____

PERSONAL DATA – PRIMARY CONTACT

1. **Name of Spouse Living at Home (Well Spouse):** _________________________________
   DOB: _________________ SSN: _____-____-_____
   Street Address: ____
   City, State, Zip: ____
   County: ________________ Day Phone: _____________ Eve. Phone: _________________
   Email Address: ____
   Employer: __________________ Retirement Date: ______________ Veteran ___Y ___ N

   Other Spouse (Medical Applicant): ____
   DOB: __________ SSN: _____-____-_____
   Employer: __________________ Retirement Date: ______________ Veteran ___Y ___ N

2. **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: ______________________________
____
____

Does 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 provide caretaking services? If so, please provide dates and services provided:** ______________________________
____
____

<u>LIVING ARRANGEMENTS</u>

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	________	________

<u>PROPERTY</u>

List your own 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>	<u>Value</u>	<u>Ownership</u>
Tax assessed value:	__________	________
Mortgage Balance:	__________	________
Type of Mortgage (i.e., reverse?)	__________	________
Year of Purchase:	__________	________
Purchase Price:	__________	________

<u>Other Real Estate</u>
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: ____________________

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.***

<u>MEDICAL DATA</u> (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

	Husband	Wife	Other Household Member
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 taking out monies for federal income taxes, health insurance, or any other reason).

____

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

$________________ Transportation (including auto & auto insurance)

$________________ Life Insurance Premiums

$________________ Health Insurance Premiums

$________________	Federal and State Income Taxes
$ _______________	Child/Spousal Support
$ _______________	Dependent Care
$ _______________	Medicare Payment
$ _______________	Special Needs Payments (for elderly or disabled household member)
$ _______________	Work-related Expenses (uniforms, tools, etc)
$________________	Other (list: ____)
$________________	**TOTAL MONTHLY NON-SHELTER EXPENSES**

E. GIFTS

Please list all gifts made in the last 5 years in excess of $1,000 made to any individual or group of individuals ***(attach separate sheet if necessary)***. **Gifts include cash gifts, transfers of real property (land, buildings, etc), personal property(cars, boats, jewelry, artwork, etc), annuity funds, burial insurance policy funds, life insurance funds, etc. A gift also includes a loan or credit card payments made for another person. For example, a gift occurs if the parent makes a payment on existing student loan or credit card for a child.**

Recipient_______________________________ Date__________ Amount $____________

Recipient_______________________________ Date__________ Amount $____________

Recipient_______________________________ Date__________ Amount $____________

Recipient_______________________________ Date__________ Amount $____________

Recipient_______________________________ Date__________ Amount $____________

Recipient_______________________________ Date__________ Amount $____________

Recipient_______________________________ Date__________ Amount $____________

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 <u>TRUSTS, WILLS, AND POWERS OF ATTORNEY</u>.**

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: ______________________________, 2009

____________________________________ ____

Name of person who prepared this form Signature