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MEDICAID INTAKE FORM (SINGLE)

Matter Reference: _____ Client Name: _____

Name of person requesting Medicaid : _____

PERSONAL DATA

1. **Name:** _____
   DOB: _____ SSN: _____-____-_____ County: _____
   Street Address: _____
   City, State, Zip: _____
   Day Phone: _____ Eve. Phone: _____ Cell Phone: _____
   Email Address: _____
   Employer: _____ Retirement Date: _____ Veteran ___Y ___ N

2. **If you are currently in health care facility:**
   Name of Facility: _____
   Address: _____
   Type of facility: _____ Level of care: _____ Date of Admission _____
   Mental Health Status: _____
   Physical Health Status: _____
   Current source of payments for 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 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:** _____
_____

LIVING ARRANGEMENTS

What is your current living arrangement?

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 your own property with estimated fair market values in the broad categories provided. Specify how the property is held. **Please attach a copy of all deeds.**

Family Residence	**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

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.

MEDICAL DATA

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

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 anyone 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

(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 made a will, signed a trust, powers of attorney, or other estate planning documents? Yes ☐ No ☐

B. Do you anticipate receiving an inheritance? Yes ☐ No ☐
Approximate size? _____

C. Are you 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.

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: _____.

_____ _____

Name of person who prepared this form Signature