<u>ASSET PROTECTION QUESTIONNAIRE - MARRIED COUPLE</u>

Note: This form is extremely important. Your accuracy and completeness in responding will help us best represent you.

Date_______________ Completed By: ____

Case Name: ____

A. PERSONAL DATA - CLIENTS

	HUSBAND	WIFE
Full Name:	____________________	____________________
DOB	____________________	____________________
SS#	____________________	____________________
Citizen?	____________________	____________________
Veteran?	____________________	____________________

Street Address____

City____ State__________ Zip____________

County_________________________ Municipality _____________________ (For Property Taxes)

School District: ___________________________

Home Telephone: _______________________ Work Telephone: ___________________________

Either Spouse a Veteran? Yes ☐ No ☐ **Dates of Service - ________________ Wartime? ________________**

Do you have your original Discharge Papers - DD-214? Yes ☐ No ☐

Are your registered for DEERS? Yes ☐ No ☐

Have you applied for TRICARE FOR LIFE? Yes ☐ No ☐

Have you applied for VA Enhanced Pension? Yes ☐ No ☐ **If yes, when ______________________**

Is eiter spouse receiving Enhanced Pension? Yes ☐ No ☐ **Which spouse? ____________________**

Have you prepared a Power of Attorney for financial matters? Provide the name of your agent.
Husband: ______________________ **Dated:** ________________
Wife: ______________________ **Dated:** ________________

Have you prepared a Power of Attorney for health care? Provide the name of your agent.
Husband: ______________________________ **Dated:** _____________________
Wife: ______________________________ **Dated:** _____________________

Have you prepared a Living Will? Provide the name of your surrogate.

Husband: ______________________________ **Dated:** _____________________
Wife: ______________________________ **Dated:** _____________________

Who has the original documents? ____
Name of Preparer: ____

Do you have your Discharge Records DD-214? __________________________________

B. **PRIMARY CONTACT DATA - PERSON WE SHOULD CONTACT FIRST**

FULL NAME____
(PRINT FULL LEGAL)

STREET ADDRESS ____

CITY____ STATE____________ ZIP_____________

BIRTH DATE____SOCIAL SECURITY NO.___________________________________

HOME TELEPHONE: ________________________________ WORK TELEPHONE: ____________________________________

FAX NUMBER: ___________________________________ EMAIL HOME: _______________ WORK: ________________

RELATION TO CLIENT: _______________________________ IF AGENT UNDER POA – DATE OF POA: ____________________

BEST TIME TO CALL: _________________________

MAY WE CONTACT YOU AT WORK? YES ☐ NO ☐

SHOULD WE EMAIL YOU AT WORK OR HOME? WORK ☐ HOME ☐

SECONDARY CONTACT - PERSON TO CONTACT IF PRIMARY IS UNAVAILABLE

FULL NAME:____
(PRINT FULL LEGAL NAME)

STREET ADDRESS ____

CITY____ STATE____________ ZIP_____________

BIRTH DATE____ SOCIAL SECURITY NO.___________________________________

HOME TELEPHONE: ________________________________ WORK TELEPHONE: ____________________________________

FAX NUMBER: ___________________________________ EMAIL HOME: _______________ WORK: ________________

RELATION TO CLIENT: _______________________________ IF AGENT UNDER POA – DATE OF POA: ____________________

BEST TIME TO CALL: ________________________

MAY WE CONTACT YOU AT WORK? YES ☐ NO ☐

SHOULD WE EMAIL YOU AT WORK OR HOME? WORK ☐ HOME ☐

C. MEDICAL DATA

1. HEALTH

NAME OF ILL SPOUSE ____

DIAGNOSIS____

PROGNOSIS____

COURSE OF TREATMENT____

WHERE ILL SPOUSE CURRENTLY RESIDES____

NAME OF WELL SPOUSE ____

HEALTH OF WELL SPOUSE ____

WHERE WELL SPOUSE CURRENTLY RESIDES ____

IF EITHER SPOUSE HAS ALREADY ENTERED A NURSING HOME, PLEASE INDICATE THE NAME OF THE NURSING HOME AND THE DATE FIRST ENTERED ON A CONTINUOUS BASIS____

2. PHYSICIAN

(HUSBAND)

FULL NAME OF PRIMARY PHYSICIAN ____

STREET ADDRESS____

CITY______________________________ STATE__________ ZIP__________

(WIFE)

FULL NAME OF PRIMARY PHYSICIAN ____

STREET ADDRESS____

CITY______________________________ STATE__________ ZIP__________

ARE YOU CURRENTLY RECEIVING PACE/PACENET (PHARMACEUTICAL ASSISTANCE CONTRACT FOR THE ELDERLY) OR ANY OTHER STATE PHARMACEUTICAL PLAN? YES ☐ NO ☐

3. HEALTH INSURANCE/MEDICARE

(HUSBAND)
MEDICARE ID NUMBER: ______________________________
TYPE POLICY: STANDARD _______ ADVANTAGE _______ (HMO/PPO)
NAME OF COVERAGE: (EG "KEYSTONE 65") ______________________________
MEDIGAP : YES ☐ NO ☐
PROVIDER: ______________________________
POLICY NUMBER: ______________________________

PREMIUM AMOUNT: ____
PAYABLE : MONTHLY ☐ QUARTERLY ☐ YEARLY ☐
OTHER HEALTH INSURANCE: ______________________________________
ID NUMBER: ____
PREMIUM AMOUNT: ____
MEDICARE PART D: DATE ACCEPTED: ________________
PREMIUM: __________________
PROVIDER: __________________________________

(WIFE)
MEDICARE ID NUMBER: ______________________________________
TYPE POLICY: STANDARD _______ ADVANTAGE _______ (HMO/PPO)
NAME OF COVERAGE: (EG "KEYSTONE 65") ______________________________
MEDIGAP : YES ☐ NO ☐
PROVIDER: ____
POLICY NUMBER: ____
PREMIUM AMOUNT: ____
PAYABLE : MONTHLY ☐ QUARTERLY ☐ YEARLY ☐
OTHER HEALTH INSURANCE: ______________________________________
ID NUMBER: ____
PREMIUM AMOUNT: ____
MEDICARE PART D: DATE ACCEPTED: ________________
PREMIUM: __________________
PROVIDER: __________________________________

4. LONG TERM CARE INSURANCE

(HUSBAND)

ARE YOU COVERED BY LONG TERM CARE INSURANCE? YES ☐ NO ☐
IF YES, NAME OF COMPANY: ____
POLICY NO. ________________________ DAILY BENEFIT OR POLICY VALUE: $__________________
COVERAGE: HOME HEALTH CARE ☐ ASSISTED LIVING ☐
ELIMINATION PERIOD (CIRCLE ONE): 30 60 90 120
METHOD OF QUALIFICATION: ADLS ☐ IMPAIRMENT ☐ MEDICALLY NECESSARY ☐
OTHER BENEFITS: HOME ALTERATIONS ☐ BED HOLD ☐ RESPITE CARE ☐ WAVIER OF PREMIUM ☐

(WIFE)

ARE YOU COVERED BY LONG TERM CARE INSURANCE? YES ☐ NO ☐
IF YES, NAME OF COMPANY: ____
POLICY NO. ________________________ DAILY BENEFIT OR POLICY VALUE: $__________________
COVERAGE: HOME HEALTH CARE ☐ ASSISTED LIVING ☐
ELIMINATION PERIOD (CIRCLE ONE): 30 60 90 120
METHOD OF QUALIFICATION: ADLS ☐ IMPAIRMENT ☐ MEDICALLY NECESSARY ☐
OTHER BENEFITS: HOME ALTERATIONS ☐ BED HOLD ☐ RESPITE CARE ☐ WAVIER OF PREMIUM ☐

D. MONTHLY INCOME

	HUSBAND'S MONTHLY INCOME	WIFE'S MONTHLY INCOME
SOCIAL SECURITY BENEFITS	$____________	$____________
RETIREMENT BENEFITS	$____________	$____________
DEDUCTIONS?	$____________	$____________
VA DISABILITY BENEFIT	$____________	$____________

ANNUITY INCOME	$________	$________
RENTAL INCOME	$________	$________
TOTAL MONTHLY INCOME	$________	$________

1. **PENSIONS** - PLEASE LIST THE ***GROSS PENSION AMOUNT,*** INCLUDING ANY MONIES TAKEN OUT FOR FEDERAL INCOME TAXES, HEALTH INSURANCE, OR ANY OTHER REASON. LIST THOSE EXPENSES LATER IN QUESTIONNAIRE

DOES PENSION AMOUNT INCREASE IN THE FUTURE? YES ☐ NO ☐

(A) NAME OF COMPANY: ________________________________
ACCOUNT NO: ________________________________
DEATH BENEFIT: ________________

(B) NAME OF COMPANY: ________________________________
ACCOUNT NO: ________________________________
DEATH BENEFIT: ________________

2. **SOCIAL SECURITY** - CIRCLE METHOD OF PAYMENT:

(HUSBAND)
DIRECT DEPOSIT ____ MAIL _____ NURSING HOME _____ REPRESENTATIVE PAYEE _____
FOR DIRECT DEPOSIT - NAME OF BANK: ________________________________
IF REP PAYEE - NAME: ________________________________
DOES PENSION AMOUNT INCREASE IN THE FUTURE? YES ¨ NO ¨
DO NOT INCLUDE INTEREST AND DIVIDEND INCOME ON THIS FORM.

(WIFE)
DIRECT DEPOSIT ____ MAIL _____ NURSING HOME _____ REPRESENTATIVE PAYEE _____
FOR DIRECT DEPOSIT - NAME OF BANK: ________________________________
IF REP PAYEE - NAME: ________________________________
DOES PENSION AMOUNT INCREASE IN THE FUTURE? YES ¨ NO ¨
DO NOT INCLUDE INTEREST AND DIVIDEND INCOME ON THIS FORM.

2. **ANNUITIES**

NAME OF PAYOR: ________________________________
DATE ANNUITIZED: ________________ AMOUNT OF INVESTMENT: ________________
SURRENDER CHARGES STILL IN EFFECT: ________________

NAME OF PAYOR: ________________________________
DATE ANNUITIZED: ________________ AMOUNT OF INVESTMENT: ________________
SURRENDER CHARGES STILL IN EFFECT: ________________
NAME OF PAYOR: ________________________________
DATE ANNUITIZED: ________________ AMOUNT OF INVESTMENT: ________________
SURRENDER CHARGES STILL IN EFFECT: ________________

E. **MONTHLY COST OF NURSING HOME - IF APPLICABLE**

$________________	MONTHLY NURSING HOME COST
$________________	MONTHLY PRESCRIPTION COST
$________________	MONTHLY INCONTINENT COST
$________________	MONTHLY OTHER COST
$________________	TOTAL MONTHLY COSTS

THE NURSING HOME IS PAID THROUGH ____(MONTH/YEAR).

F. **MONTHLY SHELTER EXPENSES**

(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

G.**MONTHLY NON-SHELTER LIVING EXPENSES**

$________________	FOOD
$________________	MEDICAL
$________________	CLOTHING
$________________	TRANSPORTATION (INCLUDING AUTO INSURANCE)
$________________	HOME MAINTENANCE
$________________	LIFE INSURANCE PREMIUMS
$________________	HEALTH INSURANCE PREMIUMS
$________________	CABLE TV
$________________	FEDERAL AND STATE INCOME TAXES
$________________	OTHER
$________________	TOTAL MONTHLY NON-SHELTER LIVING EXPENSES

H. ASSETS/LIABILITIES

PLEASE INSERT THE VALUE OF EACH ASSET/LIABILITY IN THE APPROPRIATE SPACE.

ASSETS	LOCATION OR BANK WHERE HELD	HOW TITLED - TAKE FROM STATEMENT OR DEED	DEBT?	VALUE TODAY OR AS OF ADMISSION DATE
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE) BLOCK#__________ LOT#________ (OBTAIN FROM TAX BILL)				
OTHER REAL ESTATE				
ADDITIONAL AUTOMOBILES				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

RESIDENCE

DATE PURCHASED: ________________________ COST OF PURCHASE: ____________________

IMPROVEMENTS MADE: ___________________________

HAS THE OWNERSHIP CHANGED AT ANY TIME SINCE YOUR PURCHASE? _____________________________

IS THE HOME SUBJECT TO A MORTGAGE? _____________________________________

IF YES, NAME OF MORTGAGE COMPANY AND BALANCE OWED: ____

HOMEOWNERS INSURANCE COMPANY: ____

IF TRAILOR, LOCATION OF TITLE: ____

PARCEL NO: ____

DESCRIPTION OF HOME (EG SINGLE FAMILY ROW): ____

UNUSUAL ASPECTS OF PROPERTY: ____

OTHER REAL ESTATE

NAMES OF DEED: ____

STREET____CITY_________________STATE__________ZIP__________

PROPERTY TAXES PAID TO: MUNICIPALITY: __________________________________ COUNTY: ___________________________________

DATE PURCHASED: ____________________________________ COST: _______________________________________

IMPROVEMENTS: ______________________________________ COST: _______________________________________

HOMEOWNERS INSURANCE CO: __________________________________ POLICY NO. __________________________________

RENTAL PROPERTY: YES ☐ NO ☐ RENTAL INCOME AMOUNT: ____________________________

DEPRECIATED: YES ☐ NO ☐ VALUE OF DEPRECIATION: ____________________________

PARCEL NO: ____

DESCRIPTION OF HOME (EG SINGLE FAMILY ROW): ____

UNUSUAL ASPECTS OF PROPERTY: ____

I. GIFTS

PLEASE LIST GIFTS MADE, THE TOTAL OF WHICH EXCEEDS $500 IN ANY ONE MONTH, TO AN INDIVIDUAL OR GROUP OF INDIVIDUALS, WITHIN THE PAST 60 MONTHS (FIVE YEAR LOOKBACK):

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 SO, PLEASE PROVIDE COPIES

J. INCOME TAXES

DATE OF LAST FEDERAL INCOME TAX RETURN FILED: ______________________________

LAST STATE RETURN FILED: ____

NAME OF STATE:____

DATE OF LAST PROPERTY TAX REBATE RETURN FILED - IF PA RESIDENT

AMOUNT RECEIVED ________________________

PREPARER: ____

PHONE NO: ____

K. CHILDREN (IF APPLICABLE)

CHILD FULL LEGAL NAME AND DOMICILE (STATE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MARITAL STATUS	CHILDREN	MINOR CHILDREN Y/N?

ARE ALL OF YOUR CHILDREN IN GOOD HEALTH? YES ☐ NO ☐

ARE ANY OF YOUR CHILDREN BLIND? YES ☐ NO ☐

ARE ANY OF YOUR CHILDREN DISABLED? YES ☐ NO ☐

HAVE ALL OF YOUR CHILDREN COMPLETED THEIR EDUCATION? YES ☐ NO ☐

ARE ANY OF YOUR CHILDREN RECEIVING SSI OR OTHER FORM OF GOVERNMENT ENTITLEMENT? YES ☐ NO ☐

DO ANY OF YOUR CHILDREN LIVE WITH YOU IN YOUR HOME? YES ☐ NO ☐

IF YES, NAME OF CHILD______________________________

HOW LONG HAS CHILD LIVED WITH YOU?

HAS CHILD'S ASSISTANCE PERMITTED YOU TO KEEP ILL SPOUSE AT HOME? YES ☐ NO ☐

PLEASE DESCRIBE: ______________________________

PREVIOUS MARRIAGES? YES ☐ NO ☐

HUSBAND ________________ WIFE ______________________

CHILDREN?

HUSBAND ________________ WIFE ______________________

DATE OF DIVORCE:

HUSBAND ________________ WIFE ______________________

L. MISCELLANEOUS

DO YOU HAVE ANY OTHER LEGAL ISSUES WHICH I SHOULD BE AWARE OF? YES ☐ NO ☐

IF YES, PLEASE EXPLAIN ____

____

M. REFERRAL

BY WHOM WERE YOU REFERRED TO THIS OFFICE?

NAME____

STREET ADDRESS____

CITY____ STATE___________ ZIP_____________

N. CERTIFICATION

THE UNDERSIGNED HEREBY REPRESENTS TO THE LAW OFFICES OF LEONARD L. SHOBER, P.C., 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:

____

CLIENT OR REPRESENTATIVE

MEDICAID PLANNING PERSONAL DATA SHEET

CLIENT NAMES____

A. DISPOSITIVE INTENTIONS

1. SPOUSE AND CHILDREN

(HUSBAND)
DO YOU WISH TO PROVIDE PRIMARILY FOR YOUR SURVIVING SPOUSE AND SECONDARILY FOR YOUR CHILDREN?
YES ☐ NO ☐

DO YOU WISH TO TREAT ALL YOUR CHILDREN EQUALLY? YES ☐ NO ☐

IF NOT, WHY NOT?____

IS THERE ANYONE YOU WISH TO LEAVE OUT OF YOUR WILL? YES ☐ NO ☐

WHO AND WHY?____

SHOULD THIS BE MENTIONED IN THE WILL? YES ☐ NO ☐

(WIFE)
DO YOU WISH TO PROVIDE PRIMARILY FOR YOUR SURVIVING SPOUSE AND SECONDARILY FOR YOUR CHILDREN?
YES ☐ NO ☐

DO YOU WISH TO TREAT ALL YOUR CHILDREN EQUALLY? YES ☐ NO ☐

IF NOT, WHY NOT?____

IS THERE ANYONE YOU WISH TO LEAVE OUT OF YOUR WILL? YES ☐ NO ☐

WHO AND WHY?____

SHOULD THIS BE MENTIONED IN THE WILL? YES ☐ NO ☐

2. OTHER BENEFICIARIES

(HUSBAND)
DO YOU WANT YOUR WILL TO BENEFIT ANYONE OTHER THAN CHILDREN? YES ☐ NO ☐
IF SO, PLEASE LIST THE NAME OF BENEFICIARY AND RELATIONSHIP:

(1) NAME______________________________ RELATIONSHIP____________________

STREET ADDRESS____

CITY______________________________ STATE__________ ZIP__________

AMOUNT: $____

(2) NAME______________________________ RELATIONSHIP____________________

STREET ADDRESS____

CITY____ STATE__________ ZIP_____________

AMOUNT: $____

(3) NAME____ RELATIONSHIP_________________________

STREET ADDRESS____

CITY____ STATE__________ ZIP_____________

AMOUNT: $____

(WIFE)
DO YOU WANT YOUR WILL TO BENEFIT ANYONE OTHER THAN CHILDREN? YES ☐ NO ☐
IF SO, PLEASE LIST THE NAME OF BENEFICIARY AND RELATIONSHIP:

(1) NAME____ RELATIONSHIP_________________________

STREET ADDRESS____

CITY____ STATE__________ ZIP_____________

AMOUNT: $____

(2) NAME____ RELATIONSHIP_________________________

STREET ADDRESS____

CITY____ STATE__________ ZIP_____________

AMOUNT: $____

(3) NAME____ RELATIONSHIP_________________________

STREET ADDRESS____

CITY____ STATE__________ ZIP_____________

AMOUNT: $____

B. EXECUTOR

WHO DO YOU WISH TO SERVE AS YOUR EXECUTOR?

(HUSBAND)
FIRST CHOICE____
SECOND CHOICE____

(WIFE)
FIRST CHOICE____

SECOND CHOICE____

C. TRUSTEE

WHO DO YOU WANT TO SERVE AS YOUR TRUSTEE?

(HUSBAND)
FIRST CHOICE____

SECOND CHOICE____

(WIFE)
FIRST CHOICE____

SECOND CHOICE____

D. LIVING WILL

(HUSBAND)
DO YOU WANT YOUR LIVING WILL TO PROVIDE FOR WITHDRAWAL OF ARTIFICIAL FOOD AND FLUID? YES ☐NO ☐

DO YOU WANT YOUR HEALTH CARE AGENT TO CONSULT WITH ANY OTHER PERSON PRIOR TO ACTING? YES ☐ NO ☐

IF YES, WITH WHOM?____

NAME OF PROPOSED HEALTH CARE AGENT____
(USUALLY FAMILY MEMBER OR FRIEND)

STREET ADDRESS____
(IF OTHER THAN CHILD)

CITY______________________________ STATE__________ ZIP__________

NAME OF PROPOSED ALTERNATE HEALTH CARE AGENT____

STREET ADDRESS____
(IF OTHER THAN CHILD)

CITY______________________________ STATE__________ ZIP____________

(WIFE)

DO YOU WANT YOUR LIVING WILL TO PROVIDE FOR WITHDRAWAL OF ARTIFICIAL FOOD AND FLUID? YES ☐ NO ☐

DO YOU WANT YOUR HEALTH CARE AGENT TO CONSULT WITH ANY OTHER PERSON PRIOR TO ACTING? YES ☐ NO ☐

IF YES, WITH WHOM?______________________________

NAME OF PROPOSED HEALTH CARE AGENT______________________________
(USUALLY FAMILY MEMBER OR FRIEND)

STREET ADDRESS______________________________
(IF OTHER THAN CHILD)

CITY______________________________ STATE__________ ZIP____________

NAME OF PROPOSED ALTERNATE HEALTH CARE AGENT______________________________

STREET ADDRESS______________________________
(IF OTHER THAN CHILD)

CITY______________________________ STATE__________ ZIP____________

E. POWER OF ATTORNEY

(HUSBAND)
NAME OF PROPOSED FINANCIAL AGENT______________________________
(USUALLY FAMILY MEMBER OR FRIEND)

STREET ADDRESS______________________________
(IF OTHER THAN CHILD)

CITY______________________________ STATE__________ ZIP____________

NAME OF PROPOSED ALTERNATE FINANCIAL AGENT______________________________

STREET ADDRESS______________________________
(IF OTHER THAN CHILD)

CITY______________________________ STATE__________ ZIP____________

(WIFE)
NAME OF PROPOSED FINANCIAL AGENT______________________________
(USUALLY FAMILY MEMBER OR FRIEND)

STREET ADDRESS______________________________
(IF OTHER THAN CHILD)

CITY____ STATE____________ ZIP________________

NAME OF PROPOSED ALTERNATE FINANCIAL AGENT____

STREET ADDRESS____
(IF OTHER THAN CHILD)

CITY____ STATE____________ ZIP________________