ASSET PROTECTION QUESTIONNAIRE - INDIVIDUAL

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

Date_____ Completed By: _____

A. PERSONAL DATA-CLIENT

1. Client/Applicant

Full Name _____
(Print name as shown on your bank accounts and checks)

Street Address_____

City_____ State_____ Zip_____

County of Domicile _____ Municipality (Tax) _____

Birth Date_____ Social Security No._____

Home Telephone: _____ Facility Telephone: _____

Prefer that we contact (please circle) Client Contact #2 Contact #2A

Prefer correspondence to (please circle) Client Contact #2 Contact #2A

If widowed, please list name and date of death of spouse - if divorced list date of divorce

Spouse Name: _____ Date of Death/Divorce: _____

U.S. Citizen? Yes ☐ No ☐

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.
_____ Dated: _____

Have you prepared a Power of Attorney for health care? Provide the name of your agent.
_____ Dated: _____

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

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

2. CONTACT OR AGENT - Primary contact - usually agent under POA.

Full Name _____
(Full legal name)

Street Address_____

City_____ State_____ Zip_____

Birth Date_____ Social Security No._____

Home Telephone: _____ Work Telephone: _____

Fax: _____ Email: (1) _____ (2) _____

Relation to Client/Applicant: _____ If Agent Date of POA: _____

Prefer that we contact you at (please circle) Work Home

SECOND CONTACT OR AGENT - Additional contact person for Client

Full Name _____
(Full legal name)

Street Address_____

City_____ State_____ Zip_____

Birth Date_____ Social Security No._____

Home Telephone: _____ Work Telephone: _____

Fax: _____ Email: (1) _____ (2) _____

Relation to Client/Applicant: _____ If Agent Date of POA: _____

Prefer that we contact you at (please circle) Work Home

3. Referral

How were you referred to our office? _____

Name of Referral: _____ Address: _____

B. MEDICAL DATA - CLIENT/ELDER/APPLICANT

1. HEALTH - IF RELEVANT TO PLANNING

DIAGNOSIS _____

PROGNOSIS _____

COURSE OF TREATMENT _____

WHERE APPLICANT CURRENTLY RESIDES:

_____

IS THERE ANYONE LIVING WITH THE APPLICANT? YES NO
WHO IS LIVING WITH THE APPLICANT? _____
RELATIONSHIP TO APPLICANT? _____
HOW LONG HAS THE PERSON BEEN LIVING THERE? _____
DOES THIS PERSON OWN THEIR OWN HOME OR HAVE A PLACE TO LIVE? YES NO
HAS THIS PERSON PROVIDING ASSISTANCE TO KEEP APPLICANT AT HOME? _____
FOR HOW LONG? _____ **LONGER THAN 2 YEARS? YES NO**
IS YOUR DOCTOR AWARE OF THIS RELATIONSHIP YES NO

IF APPLICANT 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

FULL NAME OF PRIMARY PHYSICIAN

_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

3. HEALTH INSURANCE PLAN

ARE YOU CURRENTLY ON MEDICARE? YES ☐ NO ☐
DATE PART B BENEFITS BEGAN (FROM CARD) _____
ID NUMBER: _____

SUPPLEMENTAL INSURANCE OR MEDIGAP : YES ☐ NO ☐
CARRIER: _____
POLICY NUMBER: _____
PREMIUM AMOUNT: _____
PAYABLE : MONTHLY ☐ QUARTERLY ☐ YEARLY ☐

ARE YOU CURRENTLY ON **PACE** OR ANY OTHER STATE PHARMACEUTICAL PLAN? YES ☐ NO ☐

OTHER HEALTH INSURANCE: _____
ID NUMBER: _____
PREMIUM: _____

4. LONG TERM CARE INSURANCE

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 ☐

PREMIUM AMOUNT: _____

PAYABLE : MONTHLY ☐ QUARTERLY ☐ YEARLY ☐

C. MONTHLY INCOME -CLIENT APPLICANT- GROSS AMOUNTS

	MONTHLY INCOME
SOCIAL SECURITY BENEFITS	$_____
RETIREMENT BENEFITS (GROSS)	$_____
VA DISABILITY BENEFIT	$_____
ANNUITY INCOME	$_____
RENTAL INCOME	$_____
TOTAL MONTHLY INCOME	$_____

DO NOT INCLUDE INTEREST AND DIVIDEND INCOME ON THIS FORM.

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:

DIRECT DEPOSIT ____ MAIL _____ NURSING HOME _____ REPRESENTATIVE PAYEE _____

FOR DIRECT DEPOSIT - NAME OF BANK:_____

IF REP PAYEE - NAME:_____

3. **ANNUITIES - LIST ONLY COMMERCIAL ANNUITIES THAT ARE ANNUITIZED (LIFETIME PAYOUT):**

(A) NAME OFPAYOR:_____

DATE ANNUITIZED: _____ AMOUNT OF INVESTMENT: _____

DEATH BENEFIT OR BENEFIT CERTAIN: _____

(B) NAME OF PAYOR:_____

DATE ANNUITIZED: _____ AMOUNT OF INVESTMENT: _____

DEATH BENEFIT OR BENEFIT CERTAIN: _____

3. **VA ENHANCED PENSION:** AMOUNT: _____

CIRCLE ONE: BASIC HOUSEBOUND AID AND ATTENDANCE

D. MONTHLY COST OF FACILITY

$_____ MONTHLY RATE

$_____ MONTHLY PRESCRIPTIONS

$_____ MONTHLY INCONTINENT COST

$_____ MONTHLY OTHER COST

$_____ **TOTAL MONTHLY COSTS**

FACILITY PAID THROUGH _____(MONTH/YEAR).

E: INCOME TAXES

DATE OF LAST INCOME TAX RETURN FILED: _____

LAST STATE RETURN FILED: _____

LAST PROPERTY TAX REBTATE FILED: _____

NAME OF STATE:_____

PREPARER: _____

PHONE NO: _____

F. GIFTS

PLEASE LIST GIFTS EXCEEDING 500 IN ANY ONE MONTH, TO AN INDIVIDUAL OR GROUP OF INDIVIDUALS, WITHIN THE PAST 60 MONTHS:

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 STATE
DETAILS_____

ARE THERE ANY ASSETS REMAINING IN THE CLIENT/APPLICANT'S NAME: THIS INCLUDES LIFE INSURANCE, ANNUITIES, QUALIFIED PLANS, REAL ESTATE, TRUST FUNDS, ETC. ANY THING THAT HAS THE APPLICANT'S NAME ON IT SHOULD BE LISTED.

G. CHILDREN (IF APPLICABLE)

CHILD'S NAME	ADDRESS (WITH ZIP CODE)	TELEPHONE NUMBER	DATE OF BIRTH	SS#

DOES THE **APPLICANT** HAVE ANY CHILDREN BY A PREVIOUS MARRIAGE? YES ☐ NO ☐

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 FAMILY MEMBERS HAVE ANY PROBLEMS WITH:

AIDS? YES ☐ NO ☐
DRUG ADDICTION? YES ☐ NO ☐
ALCOHOLISM? YES ☐ NO ☐
SPENDTHRIFT? YES ☐ NO ☐

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

LENGTH OF TIME LIVING WITH PARENT? _____

IF YES, NAME OF CHILD_____

DOES CHILD HAVE ANOTHER PLACE TO LIVE YES ☐ NO ☐

DOES CHILD AT HOME HAVE DISABILITY? YES ☐ NO ☐

DID CHILD AT HOME PERMIT CLIENT/APPLICANT
TO STAY OUT OF NURSING HOME? YES ☐ NO ☐

IS YOU DOCTOR AWARE OF THIS RELATIONSHIPP

WILLING TO DO AN AFFIDAVIT TO THIS EFFECT?

G. 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
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE				
OTHER REAL ESTATE				
ADDITIONAL AUTOMOBILES				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

HOME

DOES ELDER RESIDE IN HOME?: YES ☐ NO ☐

WHAT DID YOU PAY FOR YOUR CURRENT HOME INCLUDING ANY IMPROVEMENTS?
$_____

REAL PROPERTY OTHER THAN HOME

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?
$_____

NAME OF HOMEOWNER'S INSURANCE
COMPANY_____

STREET ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE NO._____ POLICY NO._____

BURIAL AND FUNERAL ARRANGEMENTS:

PRE-NEED FUNERAL ACCOUNT: _____

DATE ESTABLISHED: _____ BANK: _____

FUNERAL HOME: _____

H. MISCELLANEOUS

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

IF YES, PLEASE EXPLAIN _____

_____

I. CERTIFICATION

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

_____

SIGNATURE

MEDICAID PLANNING PERSONAL DATA SHEET

CLIENT NAMES_____

A. DISPOSITIVE INTENTIONS

Who do want your Will to benefit?

(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?

First Choice_____
Second Choice_____

C. TRUSTEE

Who do you want to serve as your Trustee?

First Choice_____

Second Choice_____

D. LIVING WILL

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

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_____