MEDICAID PLANNING CLIENT QUESTIONNAIRE

Welcome to Hawkins Law PC. To best serve you, we need to know as much about the matter as possible. Please answer the following questions before our initial meeting:

1. **How did you hear about Hawkins Law PC? ____**

2. **Information about person completing this Questionnaire:**

   - Full Name: ____
   - Address: ____
   - E-mail Address: ________________________ Best Telephone #:___________________________
   - Relationship to person described in #3 below: ____

3. **Information about the person who may need nursing home care or in-home care:**

   - Full Name: ____
   - Date of Birth: ______________________ Social Security Number: ______________________
   - Currently in Nursing Home? ☐Yes ☐No Where? ___________________________________
   - Address (before nursing home): ____
     - Date moved into home at this address: ____
   - Most recent occupation/employer: ____
   - Highest Level of Education (for example: graduated high school) __________________________
   - Veteran of the armed forces? ☐Yes ☐No If yes, what branch? _________________________
   - Does the person have a power of attorney? ☐Yes ☐No
     - If yes, who has authority under the POA? _______________________________________
   - Does the person have a court-appointed guardian? ☐Yes ☐No
     - If yes, who is the Guardian? ____
   - Member of a federally recognized Indian Tribe? ☐Yes ☐No
   - Ethnicity? ____

- Within the last 24 months, has the person had an injury or accident that might result in a lawsuit by or against the person? ☐Yes ☐No
- Has the person ever been in a hospital, nursing home, rehab center, or a combination of these types of facilities for a continuous period of 30 days or more (even if long ago)? ☐Yes ☐No
  - If the answer is yes, what the first date of that stay? ________________________________
- Has the person previously ever received public assistance in Indiana or any other state? (Medicaid, food stamps, etc)? ☐Yes ☐No
- Does the person have Long Term Care Insurance? ☐Yes ☐No
  - If yes, name of company: ____
- Does the person have a pre-paid funeral? ☐Yes ☐No
  - If yes, name of funeral home: ____
- What is the marital status of the person?

  ☐ Single (never married)

  ☐Married (Go to #4)

  ☐ Widowed – Name and date of death of each deceased spouse:

  Name: ____________________________Date of death: _______________________

  Name: ____________________________Date of death: _______________________

  Name: ____________________________Date of death: _______________________

  ☐Divorced – Name of each ex-spouse and date of divorce:

  Name: ____________________________Date of divorce: _____________________

  Name: ____________________________Date of divorce: _____________________

  Name: ____________________________Date of divorce: _____________________

4. Current Spouse of the person (if applicable):

- Full Name: _____________________________Date of Marriage: ____________________________
- Address: ____
- E-mail Address: _________________________ Best Telephone #:____________________________

5. Children of the person needing nursing home care:

Full Name	E-mail Address:	Mailing Address	Best Telephone #:

Are any of the person's children disabled? ☐Yes ☐No Deceased? ☐Yes ☐No

Names of disabled or deceased children: ____

6. Income Sources of the person needing care (check all that apply):

☐ Social Security Amount per month: _______________

☐ Pension Amount per month: _______________ Company: ____________________

☐ PERF Amount per month: _______________ Describe: _____________________

☐ VA Benefits Amount per month: _______________

☐ Farm Income Amount per month: _______________ Farmer: ______________________

☐ Other Amount per month: _______________Describe: _____________________

7. Income Sources of Spouse, if applicable (check all that apply):

☐ Social Security Amount per month: _______________

☐ Pension Amount per month: _______________ Company: ____________________

☐ PERF Amount per month: _______________ Describe: _____________________

☐ VA Benefits Amount per month: _______________

☐ Farm Income Amount per month: _______________ Farmer: ______________________

☐ Other Amount per month: _______________Describe: _____________________

8. **Resources/Assets of the person and spouse, if applicable:**

(Feel Free to add pages if necessary)

Type of Asset: Brief Description Approximate Value

☐ Real Estate ____

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☐ Bank Accounts/CDs:____

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☐ Investments:____

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☐ IRA/401K: ____

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☐ Annuities: ____

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☐ Stocks: ____

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____

☐ Savings Bonds____

____

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☐ Cash (Currency)____

☐ Life Insurance:____

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☐ Vehicles: ____

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☐ Expected Inheritance: ____

9. **Gifts/Transfers:** Within the past five years, has the person needing care or that person's spouse made any gifts or transfers to any other person, for any reason? Examples include gifts of cash, by check, transfers of any interest in real estate, giving someone a vehicle or adding someone to the title of a vehicle etc.

☐Yes ☐No

Type of Gift/Transfer:	Date of Gift/Transfer:	Amount or Value of Gift/Transfer:
Example: *Cash Gift*	*April 2016*	*$1,000.00*

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10. Has the person or the spouse made any loans to anyone, which have not yet been paid back?

☐Yes ☐No If yes, describe: ________________________________

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11. Please use this space to list any specific questions or topics you would like to discuss with the attorney or to elaborate on any answers given above.

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