BRADY | COBIN
LAW GROUP, PLLC
HONORING THE LIFE, WORK AND CHARITY OF EVERY INDIVIDUAL

Medicaid Planning Questionnaire

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend) during a time when there may be a need for Medicaid Planning. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be ignored. Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

Individual Completing Questionnaire

Full Legal Name: _____ Nickname _____

Address: _____

City: _____ State: _____ Zip: _____

Best Phone Number: _____ Email: _____

Relationship to Client: _____

919.782.3500
WWW.NCESTATEPLANNING.COM
4141 PARKLAKE AVE, STE 130
RALEIGH, NC 27612

CLIENT AND SPOUSE

A. Client

Full Legal Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number (last 4): _____

US Citizen: ☐Yes ☐No Military Service ☐Yes ☐No If Yes, Service Dates _____

☐Married ☐Separated ☐Divorced ☐Deceased ☐Not Married

If in Currently in Facility
Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Entrance _____

B. Spouse

Full Legal Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number (last 4): _____

US Citizen: ☐Yes ☐No Military Service ☐Yes ☐No If Yes, Service Dates _____

If in Currently in Facility
Name of Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Entrance _____

CHILDREN'S INFORMATION

Child 1

Full Legal Name: _____ Nickname _____

Date of Birth: _____ Parent: ☐Client #1 ☐Client #2 ☐Both ☐Adopted/Other _____

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____ Phone: _____

Status: ☐Married, Spouse's name: _____ ☐Divorced ☐Widowed ☐Single

Special Needs: ☐Medical ☐Educational ☐Financial

Grandchildren	Parents	Age	Special Needs
			☐
			☐
			☐
			☐
			☐

Child 2

Full Legal Name: _____ Nickname _____

Date of Birth: _____ Parent: ☐Client #1 ☐Client #2 ☐Both ☐Adopted/Other _____

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____ Phone: _____

Status: ☐Married, Spouse's name: _____ ☐Divorced ☐Widowed ☐Single

Special Needs: ☐Medical ☐Educational ☐Financial

Grandchildren	Parents	Age	Special Needs
			☐
			☐
			☐
			☐
			☐

Child 3

Full Legal Name: _____ Nickname _____

Date of Birth: _____ Parent: ☐ Client #1 ☐ Client #2 ☐ Both ☐ Adopted/Other _____

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____ Phone: _____

Status: ☐ Married, Spouse's name: _____ ☐ Divorced ☐ Widowed ☐ Single

Special Needs: ☐ Medical ☐ Educational ☐ Financial

Grandchildren	Parents	Age	Special Needs
			☐
			☐
			☐
			☐
			☐

Child 4

Full Legal Name: _____ Nickname _____

Date of Birth: _____ Parent: ☐ Client #1 ☐ Client #2 ☐ Both ☐ Adopted/Other _____

Home Address: _____ City _____ State _____ Zip _____

Email Address: _____ Phone: _____

Status: ☐ Married, Spouse's name: _____ ☐ Divorced ☐ Widowed ☐ Single

Special Needs: ☐ Medical ☐ Educational ☐ Financial

Grandchildren	Parents	Age	Special Needs
			☐
			☐
			☐
			☐
			☐

PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

A. Responsible for Client

1. Name: _____ Phone: _____ Relation: _____
2. Name: _____ Phone: _____ Relation: _____
3. Name: _____ Phone: _____ Relation: _____

B. Responsible for Spouse

1. Name: _____ Phone: _____ Relation: _____
2. Name: _____ Phone: _____ Relation: _____
3. Name: _____ Phone: _____ Relation: _____

UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

HEALTH RELATED PROBLEMS

Please describe any specific health-related problems.

A. Client

B. Spouse

CAPACITY

A. Memory and Understanding

Are there any known problems with memory or understanding

Client: ☐Yes ☐No

Spouse: ☐Yes ☐No

If yes, please explain:

B. Other Issues

	Client	Spouse
Able to sign name?:	☐Yes ☐No	☐Yes ☐No
Able to speak?:	☐Yes ☐No	☐Yes ☐No
Able to recognize friend and family?:	☐Yes ☐No	☐Yes ☐No
Cognizant of property and possessions?:	☐Yes ☐No	☐Yes ☐No
Able to leave current residence?:	☐Yes ☐No	☐Yes ☐No

PHYSICIAN INFORMATION

	Client	Spouse
Physician's Name:	_____	_____
Specialty:	_____	_____
Address:	_____	_____
	_____	_____
Business Phone:	_____	_____

HOSPITAL/LONG-TERM CARE/ASSISTED LIVING PLACEMENT

A. Client

Currently in Hospital? ☐Yes ☐No If yes, date admitted:

Name/Location of Hospital: _____

Description of medical issue: _____

_____

Currently in Hospital? ☐ Yes ☐ No If yes, date admitted:

Name/Location of Hospital: _____

Description of medical issue: _____

_____

Is LTC placement expected? ☐ Yes ☐ No

If so, likely to return home? ☐ Yes ☐ No

RESIDENCE

If residence is owned, complete part A. If residence is rented, complete part B

A. Residence Owned

Owners: How is title held? _____

Fair Market Value $ Mortgage Balance $ _____

Is there a reverse mortgage ☐ Yes ☐ No Mortgage terms: _____

If the property is rental property, please provide the following:

Number of units: _____ Currently being rented? ☐ Yes ☐ No

Are tenants under lease? ☐ Yes ☐ No

How was property acquired? ☐ Purchased ☐ Inherited

If Purchased: Date of Purchase _____ Purchase Price $ _____

If Inherited: Date of Inheritance _____ Value when inherited $ _____

If improvements have been made to the property, please detail the value and nature of them:

If at least one occupant of the residence is a child of the individual in need of long-term care, has that child lived in the residence for at least 2 years? ☐Yes ☐No

If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? ☐Yes ☐No

If so, please describe the nature and duration of the care provided:

_____

_____

Does the owner have a sibling who has lived in the house for at least 1 year? ☐Yes ☐No

If yes, does the sibling still reside in the home? ☐Yes ☐No

B. Residence Rented

Monthly rent: $_____ How is title held? _____

Type of Rental: ☐Single Family ☐Apartment ☐Residential Care

☐Life Care ☐Senior Housing

Lease agreement? ☐Yes ☐No Is rent subsidized? ☐Yes ☐No

If rent is subsidized, by whom and how much? _____

FINANCIAL INFORMATION

It is very important you indicate in each category ownership and dollar amount separately, as well as total value

MONTHLY INCOME

SOURCE	P. CLIENT	SPOUSE	JOINT	TOTAL
Wages	$	$	$	$
Pension	$	$	$	$
Social Security	$	$	$	$
Investments	$	$	$	$
Other	$	$	$	$
Total Value	$	$	$	$

ASSET INFORMATION AS OF _____ - Please provide total amount for each type of asset and who owns

TYPE OF ASSET	P. CLIENT	SPOUSE	JOINT	TOTAL
Cash, Checking, Savings, CDs, Money Market & Cash Management Accounts	$	$	$	$
Investment/Broker-held Accounts (not including cash) and Mutual Fund Accounts	$	$	$	$
Retirement Accounts: IRA, 401k, 403B, SEP, etc.	$	$	$	$
Life Insurance: death benefit and cash value	D.B.$ C.V.$	D.B.$ C.V.$	D.B.$ C.V.$	D.B.$ C.V.$
Stocks: you hold (not in brokerage accounts)	$	$	$	$
Bonds: bonds you hold (not in brokerage accounts)	$	$	$	$
Annuities: $=original amount invested date=month/ year purchased CV=Current Value	$_____d:__/__ CV_____	$_____d:__/__ CV_____	$_____d:__/__ CV_____	$____d:__/__ CV_____
Real estate: residence (per tax bill)	$	$	$	$
Real estate: other	$	$	$	$
Vehicles: automobile, motorcycle, boats, snowmobiles,	$	$	$	$
TOTAL ASSETS	$	$	$	$

OTHER ASSETS NOT LISTED:

TYPE	P. CLIENT	SPOUSE	JOINT	TOTAL
	$	$	$	$
	$	$	$	$
Total Value	$	$	$	$

LIABILITIES:

TYPE	P. CLIENT	SPOUSE	JOINT	TOTAL
Mortgage	$	$	$	$
Loans Payable	$	$	$	$
Other	$	$	$	$
Total Value	$	$	$	$

BUSINESS INTEREST:

TYPE	P. CLIENT	SPOUSE	JOINT	TOTAL
Farm	$	$	$	$
Partnership or LLC interest	$	$	$	$
Corporations S-Corp? ☐	$	$	$	$
Other:	$	$	$	$
Total Value	$	$	$	$

Other things you think we should know:

EXEMPT RESOURCES

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

	Client	Spouse
Burial Plot:	☐Yes ☐No	☐Yes ☐No
Irrevocable burial fund contract:	☐Yes ☐No	☐Yes ☐No

MONTHLY COST OF LIVING

A. Housing (Estimated per month)

	Client	Spouse	Joint
1. If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*:	$	$	$
2. If home is rented, total rent, including maintenance. fees, if any:	$	$	$

* Is the senior citizen real property tax exemption being used? ☐Yes ☐No

* Is the Veterans real property tax exemption being used? ☐Yes ☐No

B. Insurance Premiums (Per Month)

	Client	Spouse	Joint
1. Health Insurance:	$	$	$
2. Long-term care insurance:	$	$	$
3. Life Insurance:	$	$	$
4. Other: _____	$	$	$

C. Medical Expenses (Estimated per month)

	Client	Spouse	Joint
1. Non-covered Medications:	$	$	$
2. Other: _____	$	$	$
3. Other: _____	$	$	$

D. Basic Living Expenses (Estimated per month)

	Client	Spouse	Joint
1. Food:	$	$	$
2. Entertainment and travel:	$	$	$
3. Support for Children:	$	$	$
4. Other: _____	$	$	$
5. Other:	$	$	$
TOTALS (A-D):	$ 0	$ 0	$ 0

0 1 0 0

0

HEALTH AND LTC INSURANCE

Please provide copy of policy

A. Medicare

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D

☐ Medicare Supplemental ☐ Medicare Advantage

B. Health Insurance

1. Name of Private Medical Insurance Company: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Best Phone Number: _____ Policy No: _____

2. Name of Private Medical Insurance Company: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Best Phone Number: _____ Policy No: _____

3. Name of Private Medical Insurance Company: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Best Phone Number: _____ Policy No: _____

C. Long-Term Care Insurance

1. Name of LTC Insurance Company: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Best Phone Number: _____ Policy No: _____

   Daily Benefits: _____ Elimination Period: _____

CURRENT ESTATE PLANNING DOCUMENTS

Have the following estate planning documents been executed?

	Client	Spouse
1. Will	☐Yes ☐No	☐Yes ☐No
2. Living Trust	☐Yes ☐No	☐Yes ☐No
3. General Power of Attorney	☐Yes ☐No	☐Yes ☐No
4. Health Care Power of Attorney	☐ Yes ☐No	☐Yes ☐No
5. Advance Directive/Living Will	☐Yes ☐No	☐Yes ☐No
6. Other: _____	☐Yes ☐No	☐Yes ☐No
7. Other: _____	☐Yes ☐No	☐Yes ☐No
8. Other: _____	☐Yes ☐No	☐Yes ☐No

Please provide copies of any of the above-mentioned documents that exist

TRANSFERS WITHIN 60 MONTHS

Has the person needing care (or his or her spouse) gratuitously transferred property to someone other than transferor's spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**: Please include transfers for financial assistance to anyone, other than in exchange for work.

A. Client

	Recipient	Amount/Value of Gift	Date of Gift
1.			
2.			
3.			
4.			
5.			

B. Spouse

	Recipient	Amount/Value of Gift	Date of Gift
1.			
2.			
3.			
4.			
5.			

TRANSFERS TO OR FROM TRUSTS

Has the person needing care (or his or her spouse) transferred property into a Trust—like an Irrevocable Life Insurance Trust (ILIT)—or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

A. Client

	Name of Trust	Amount/Value of Gift	Date of Gift
1.			
2.			
3.			

B. Spouse

	Name of Trust	Amount/Value of Gift	Date of Gift
1.			
2.			
3.			

FIDUCIARIES & ADVISERS

(Names, city and telephone numbers, if available)

1. Investment adviser: _____
2. Accountant: _____
3. Life insurance agent: _____
4. Banker: _____
5. Executor of your estate: _____
6. Substitute executor: _____
7. Trustee: _____
8. Substitute trustee: _____
9. Attorney-in-Fact: _____
10. Substitute Attorney-in-Fact: _____
11. Health Care Agent: _____
12. Substitute Health Care Agent: _____
13. Guardian for minor children: _____
14. Substitute guardian for minor children: _____
15. Location of safe deposit box: _____

DISTRIBUTION OBJECTIVES

1. Upon your death, describe generally how you want your assets distributed:

2. If you have children and you were to die prematurely, should your children receive property at majority (age 18), at age 21, or at a later age?

3. Do you wish to make bequests to any charitable organization: ☐ Yes ☐ No If yes:

Name	Address	Amount

4. If none of your children are living when you die, how should your estate be distributed:

5. If you own an interest in a business, is there a buy-sell agreement in effect: ☐ Yes ☐ No Do you desire your interest in that business to be distributed in a particular way:

6. Do you want specific assets (like jewelry, collections, furniture or heirlooms) to go to a specific person, charity or institution: ☐ Yes ☐ No If yes, please provide schedule of gifts on separate page.

8. Are you interested in protecting your assets from the claims of your heir's creditors: ☐ Yes ☐ No

CLIENT'S GOALS

What are your goals?

CERTIFICATION

The undersigned hereby represents to Brady Cobin Law Group, PLLC that the information contained in this questionnaire (including the attached schedules) is accurate and complete, and that the undersigned understands that the law firm will rely on this information. If the information contained herein is inaccurate or incomplete, the recommendations made by Brady Cobin Law Group, PLLC may not be appropriate.

_____ _____

Signature of Client or Client Representative Date