SAVE TO COMPUTER BEFORE COMPLETING -- THEN OPEN IN ADOBE

WEB BROWSER WILL NOT SAVE INFO -- COMPLETE ONLY IN ADOBE PROGRAM

MEDICAID PLANNING QUESTIONNAIRE

PERSONAL DATA

(Husband)
Full Legal Name_____
(First) (Middle) (Maiden) (Last)
Other Names known by: _____

(Wife)
Full Legal Name_____
(First) (Middle) (Maiden) (Last)
Other Names known by: _____

Physical Address_____

City_____ Parish_____ State_____ Zip_____

Mailing Address_____
(If Different)
City_____ Parish_____ State_____ Zip_____

(Husband)
Birth Date_____

(Wife)
Birth Date_____

Social Security No._____

Social Security No._____

U.S. Citizen? ◯ Yes ◯ No

U.S. Citizen? ◯ Yes ◯ No

Veteran? ◯ Yes ◯ No

Veteran? ◯ Yes ◯ No

MEDICAL DATA

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 first date entered on a continuous basis_____

If either spouse has a caregiver, please give his or her name _____

MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$_____	$_____
Retirement Benefits (Gross)	$_____	$_____
VA Disability Benefit	$_____	$_____
Annuity Income	$_____	$_____
Rental Income	$_____	$_____
Royalty Income	$_____	$_____
Other Income	$_____	$_____
Total Monthly Income	$$ 0.00	$$ 0.00

Do not include interest and dividend income on this form.

If there is a pension, please list the gross pension amount, including and monies taken out for federal income taxes, health insurance, or any other reason.

MONTHLY COST OF NURSING HOME

$_____	Monthly Nursing Home Cost
$_____	Monthly Incidental Cost
$_____	Monthly Prescription Cost
$_____	Monthly Other Cost
$0.00	**Total Monthly Costs**

The nursing home is paid through_____ (month/year).

If the nursing home facility is located in **Louisiana, Losavio and Dejean** will require the nursing home facility's Medicaid per diem rate to develop the appropriate Medicaid Complaint Annuity Plan.

As such, if applicable, please provide the Medicaid per diem rate: $_____

MONTHLY SHELTER EXPENSES
(please divide annual expenses by 12, and quarterly expenses by 3.)

$_____	Rent/ Mortgage
$_____	Real Estate Taxes
$_____	Water
$_____	Sewer
$_____	Utilities (Heat, Electric) (1/12 of last 12 months)
$_____	Homeowner's insurance premium
$_____	Condominium fees
$0.00_____	**Total Monthly Housing Expenses**

MONTHLY NON-SHELTER EXPENSES
(Please estimate)

$_____	Food
$_____	Medical
$_____	Clothing
$_____	Telephone
$_____	Transportation (including auto insurance)
$_____	Home Maintenance
$_____	Life Insurance Premiums
$_____	Health Insurance Premiums

$_____ Medicare Supplemental Insurance Premiums

$_____ Cable TV

$_____ Federal and State Income Taxes

$_____ Other

$ 0.00 **Total Monthly Non-Shelter Expenses**

ASSETS/LIABILITIES
(Please insert the value of each asset/liability in the appropriate space.)

Automobile
Make _____ Model _____ Year_____
VIN
_____
Value _____ Amount Owed _____

Other Vehicles (ATVs, Boats, RVs, Tractors, etc)
Make _____ Model _____ Year_____
VIN
_____
Value _____ Amount Owed _____

Make _____ Model _____ Year_____
VIN
_____
Value _____ Amount Owed _____

Checking Account
Name of Institution/Bank _____
Name(s) on Account _____
(As Listed on Account)
Amount in Account _____ Account # _____

Savings Account
Name of Institution/Bank _____
Name(s) on Account _____
(As Listed on Account)
Amount in Account _____ Account # _____

Money Market Account
Name of Institution/Bank _____
Name(s) on Account _____
(As Listed on Account)

Amount in Account _____ Account # _____

Certificates of Deposit

Name of Institution/Bank _____

Name(s) on Account _____

(As Listed on Account)

Amount in Account _____ Account # _____

Residence

Legal Description (Can be found in Cash Sale)

Please Attach a Copy of Cash Sale, and Attach Assessed Value or Appraisal if available.

Other Real Estate

Legal Description (Can be found in Cash Sale)

Please Attach a Copy of Cash Sale and Attach Assessed Value or Appraisal if available.

Mutual Funds

Face Amount _____ Market Value_____

Name of Institution/Bank _____

Name(s) on Account _____

(As Listed on Account)

Amount in Account _____ Account # _____

Annuities

Face Amount _____ Market Value_____

Name of Institution/Bank _____

Name(s) on Account _____

(As Listed on Account)

Amount in Account _____ Account # _____

Designated Beneficiary _____

IRA

Face Amount _____ Market Value_____

Name of Institution/Bank _____

Name(s) on Account _____

(As Listed on Account)

Amount in Account _____ Account # _____

Designated Beneficiary _____

Stocks

Face Amount _____ Market Value_____

Name of Institution/Bank _____

Name(s) on Account _____

(As Listed on Account)

Series# _____

Bonds

Face Amount _____ Market Value_____

Name of Institution/Bank _____

Name(s) on Account _____

(As Listed on Account)

Series# _____

Nursing Home Deposit

Amount _____

Clothing & Jewelry

Amount _____

Furniture & Household Goods

Amount _____

Tools & Equipment

Amount _____

Debts (Including taxes owed to State &Federal Governments) (Please do NOT include Mortgage)

_____

_____

_____

Total countable resources as of the first continuous period of institutionalization: $_____ OFFICE USE

LIFE INSURANCE & BURIAL POLICIES

COMPANY	**TYPE LI BP**	**DEATH BENEFIT VALUE**	**FACE VALUE**	**CASH VALUE**	**INSURED**	**OWNER**	**BENEFICIARY**

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

GIFTS

Please list the gifts made in excess of $100.00 in any one month, to an individual or group of individuals, within the past 60 months:

Return Filed?

Recipient_____ Date_____ Amount_____ ◯ Y/N ◯

Recipient_____ Date_____ Amount_____ ◯ Y/N ◯

Recipient_____ Date_____ Amount_____ ◯ Y/N ◯

Recipient_____ Date_____ Amount_____ ◯ Y/N ◯

CHILDREN (if applicable)

CHILD'S FULL LEGAL NAME	**ADDRESS**	**TELEPHONE NUMBER**	**DATE OF BIRTH**	**DATE OF DEATH**

Are all of your children in good health? Yes ◯ No ◯

Are any of your children receiving SSI or other forms of government entitlement? Yes ◯ No ◯

Do any of your children live with you in your home? Yes ◯ No ◯

Do any of your children provide care for you? Yes ◯ No ◯

THIRD PARTY COMPENSATION

If a licensed insurance agent, financial advisor, or other person is seeking compensation on this case, Losavio and Dejean must know of their relationship prior to the development of a Medicaid plan. **Once a Medicaid Plan is developed by way of a planning letter, no compensation-commissions or otherwise, will be made available to any third party.**

Will a third party be seeking compensation in this transaction? Yes ◯ No ◯

CERTIFICATION

The undersigned hereby represents to Losavio and Dejean that the information contained in this intake form is accurate and complete, and that the undersigned understands that Losavio and Dejean will rely on this information for purposes of developing a Medicaid Annuity plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Medicaid eligibility.

Dated:_____

Signature of Client or Client Representative:

OR

_____

Additional Comments:_____

_____

_____

_____

_____

FOR OFFICE USE ONLY
Total Value of All Non-Exempt Assets: $_____