

LAW OFFICE OF CATHERINE S. STRONG, PLLC

COLUMBIA CENTER • SUITE 3510

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MEDICAID PLANNING QUESTIONNAIRE

PERSONAL INFORMATION

	MEDICAID APPLICANT	SPOUSE
NAME		
BIRTH DATE		
CITIZENSHIP		
SOCIAL SECURITY NO.		
ADDRESS		
PHONE		
EMAIL		
VETERAN?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Marital Status: Married Single Widowed Divorced

Care Center: Assisted Living Adult Family Home Nursing Home

Name _____

Address _____

County _____

Date of Admission _____

ASSETS/RESOURCES:

Bank and Credit Union Accounts: (checking, savings or money market)

Bank/Credit Union	Owner/Name on Account	Type of Account	Balance

Stocks, Bonds, Mutual Funds, CD's:

Investment	Financial Institution	Owner/Name on Account	Balance

Life Insurance:

Company	Insured	Owner of Policy	Cash Surrender Value

Annuity:

Company	Account No.	Owner	Balance

IRA's/Other Retirement Accounts:

Company	Account Type	Owner	Balance

Real Estate:

Location	Owner	Fair Market Value

Vehicles/Boats/RV's:

Type	Year	Model	Value	Loan Balance

Other Assets:

	Burial Plots	Prepaid Funeral Plans
YES		
NO		

MONTHLY INCOME

Type	Medicaid Applicant	Spouse
Social Security		
Pension		
Veteran's Benefits		
Earned		
Other		

HOUSING COSTS:

Mortgage/Rent	
Property Taxes	
Homeowner's Insurance	
Electricity	
Phone	
Water/Garbage/Sewer	
Heat (gas, electric, oil)	

GIFTS MADE IN LAST FIVE YEARS

To Whom	What	Date	Value

ESTATE PLAN

	MEDICAID APPLICANT		SPOUSE	
Last Will and Testament	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Community Property Agreement	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Durable Power of Attorney for Finances	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Durable Power of Attorney for Health Care	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Health Care Directives/Living Will	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO