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MEDICAID PLANNING FORM - MARRIED

Your appointment with this office is: ______________________ at ______________

These questions pertain to the persons for whom we are planning. We ask a lot of questions on this form because we need a lot of information about you and your spouse for our planning for you. Do your best, but don't worry if some of the information you need to complete this form is not available to you. Please call us at if you have any questions or concerns about completing this form.

Date: **Referred by:**

1. PERSONAL INFORMATION

	HUSBAND:	**WIFE:**
Name (First, Middle, Last):		
Name you prefer to be called:		
Date of Birth:		
Place of Birth:		
SSN:		
Medicare Number:		
US Citizen?	☐ Yes ☐ No	☐ Yes ☐ No
Veteran?	☐ Yes ☐ No	☐ Yes ☐ No
Husband Home Address:		
Husband Home City, State, Zip:		
Wife Home Address:	☐ Same as Husband ☐ Different	
Wife Home City, State, Zip:	☐ Same as Husband ☐ Different	
County of Residence:		
Home Phone:		
Cell Phone:		
Home Email:		
Marriage Information:	**Date:**	**Place of Marriage:**
Contact Information (if not you, who should we contact for appointments, information, etc.?):	**Name/Relationship:** **Phone:** **Address:**	

2. CHILDREN:

1) Child's Full Legal Name:	☐ Male / ☐ Female	**Birthdate:**
Child's Address, City, State, Zip:	☐ Deceased	☐ Husband's by birth/adoption ☐ Wife's child by birth/adoption ☐ Child taken into home (not yours by birth/adoption)
Child's Phone:		**# Of Children**

2) Child's Full Legal Name:	☐ Male / ☐ Female	**Birthdate:**
Child's Address, City, State, Zip:	☐ Deceased	☐ Husband's child by birth/adoption ☐ Wife's child by birth/adoption ☐ Child taken into home (not yours by birth/adoption)
Child's Phone:		**# Of Children**

3) Child's Full Legal Name:	☐ Male / ☐ Female	**Birthdate:**
Child's Address, City, State, Zip:	☐ Deceased	☐ Husband's child by birth/adoption ☐ Wife's child by birth/adoption ☐ Child taken into home (not yours by birth/adoption)
Child's Phone:		**# Of Children**

4) Child's Full Legal Name:	☐ Male / ☐ Female	**Birthdate:**
Child's Address, City, State, Zip:	☐ Deceased	☐ Husband's child by birth/adoption ☐ Wife's child by birth/adoption ☐ Child taken into home (not yours by birth/adoption)
Child's Phone:		**# Of Children**

5) Child's Full Legal Name:	☐ Male / ☐ Female	**Birthdate:**
Child's Address, City, State, Zip:	☐ Deceased	☐ Husband's child by birth/adoption ☐ Wife's child by birth/adoption ☐ Child taken into home (not yours by birth/adoption)
Child's Phone:		**# Of Children**

6) Child's Full Legal Name:	☐ Male / ☐ Female	**Birthdate:**
Child's Address, City, State, Zip:	☐ Deceased	☐ Husband's child by birth/adoption ☐ Wife's child by birth/adoption ☐ Child taken into home (not yours by birth/adoption)
Child's Phone:		**# Of Children**

Do you have any dependents (that is someone who depends on you, in whole or in part, for their support)? ☐ Yes ☐ No – If yes, who?

Are any of your children receiving Supplemental Security Income, Social Security Disability, or, if not, has any major disabilities? ☐ Yes ☐ No
If yes, who?

3. FUNCTIONAL LIMITATIONS AND SUPPORT:

The term "activities of daily living" refers to the basic tasks of everyday life. When people are unable to perform these activities, they need help in order to cope, from either other human beings or mechanical devices (such as a walker or wheelchair) or both.

Why do we want this information? Measurement of the activities of daily living is critical because the more assistance people need with their daily activities; the more likely are they to be admitted to a nursing home or other living arrangement; to use paid home care; to use hospitals and doctors; and to die sooner rather than later.

Please check the box that most applies for each activity.

HUSBAND:

Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to do at all**
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Transferring from bed to chair	☐	☐	☐
Walking	☐	☐	☐
Feeding self	☐	☐	☐
Using the toilet	☐	☐	☐
Grooming	☐	☐	☐

Instrumental Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to do at all**
Using the telephone	☐	☐	☐
Getting out of car or public transport	☐	☐	☐
Grocery shopping	☐	☐	☐
Preparing meals	☐	☐	☐
Doing housework or handyman work	☐	☐	☐
Doing laundry	☐	☐	☐
Taking medications	☐	☐	☐
Managing money	☐	☐	☐

Place Where You Live		Since When?
☐	Single-family home	
☐	Same, but someone assists you there with above activities	
☐	Apartment or retirement living community	
☐	Assisted-living facility	
☐	Nursing home	
☐	Other:	

List the names of all persons who provide assistance or care giving for you:

WIFE:

Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to do at all**
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Transferring from bed to chair	☐	☐	☐
Walking	☐	☐	☐
Feeding self	☐	☐	☐
Using the toilet	☐	☐	☐
Grooming	☐	☐	☐

Instrumental Activities of Daily Living			
Activity	**Need No Help**	**Need Some Help**	**Unable to do at all**
Using the telephone	☐	☐	☐
Getting out of car or public transport	☐	☐	☐
Grocery shopping	☐	☐	☐
Preparing meals	☐	☐	☐
Doing housework or handyman work	☐	☐	☐
Doing laundry	☐	☐	☐
Taking medications	☐	☐	☐
Managing money	☐	☐	☐

Place Where You Live		Since When?
☐	Single-family home	
☐	Same, but someone assists you there with above activities	
☐	Apartment or retirement living community	
☐	Assisted-living facility	
☐	Nursing home	
☐	Other:	

List the names of all persons who provide assistance or care giving for you:

____

5. RESOURCES:

Monthly Income

(Do not list interest or dividend income)

SOURCE (gross income)	HUSBAND	WIFE	OTHER
Social Security:	$	$	$
Pension:	$	$	$
Other:	$	$	$
TOTAL:	$	$	$

Personal Residence

Address of Property:			
Names as they appear on deed:			
Date Acquired:		Purchase Price:	$
Mortgage Company:			
Mortgage Balance:	$	Tax-Appraised Value:	$
Current Value:	$		

Other Real Estate

Address of Property:			
Names as they appear on deed:			
Date Acquired:		Purchase Price:	$
Mortgage Company:			
Mortgage Balance:	$	Tax-Appraised Value:	$
Current Value:	$		

Address of Property:			
Names as they appear on deed:			
Date Acquired:		Purchase Price:	$
Mortgage Company:			
Mortgage Balance:	$	Tax-Appraised Value:	$
Current Value:	$		

Other Assets

These are your bank accounts, CDs, annuities, stocks, retirement plans, and the like.

Type of Asset:	
Name of Company:	
Value:	$
How is it titled?:	

Type of Asset:	
Name of Company:	
Value:	$
How is it titled?:	

Type of Asset:	
Name of Company:	
Value:	$
How is it titled?:	

Type of Asset:	
Name of Company:	
Value:	$
How is it titled?:	

Type of Asset:	
Name of Company:	
Value:	$
How is it titled?:	

Type of Asset:	
Name of Company:	
Value:	$
How is it titled?:	

Type of Asset:	
Name of Company:	
Value:	$
How is it titled?:	

Total Value of Assets on this Page:	

Life Insurance

Company Name:	
Owner:	
Insured:	
Beneficiary:	
Death Benefit (Face Value):	$
Cash Surrender Value:	$
Loan Against Policy (if any):	$

Company Name:	
Owner:	
Insured:	
Beneficiary:	
Death Benefit (Face Value):	$
Cash Surrender Value:	$
Loan Against Policy (if any):	$

Company Name:	
Owner:	
Insured:	
Beneficiary:	
Death Benefit (Face Value):	$
Cash Surrender Value:	$
Loan Against Policy (if any):	$

Company Name:	
Owner:	
Insured:	
Beneficiary:	
Death Benefit (Face Value):	$
Cash Surrender Value:	$
Loan Against Policy (if any):	$

Personal Property

List large items of personal property you own (cars, boats, RVs, farm equipment, etc.) or any valuable collections (antiques, coins, stamps, guns, etc.):

Personal Property (item)	Value
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$

Funeral/Burial

Do either or both of you have prepaid funeral or burial? ☐ Yes ☐ No

If yes, describe arrangements:

Husband:	
Wife:	

Other Insurance:

Please complete the following health insurance information as it applies to both of you.

HUSBAND:

MEDICARE

Traditional Medicare Fee-For-Service	☐ **Yes** ☐ **No**
Or	
Medicare HMO, PSO, PPO, or Private Pay Plan	☐ **Yes** ☐ **No**
Company:	

Medicare Supplement ("Medigap")	☐ **Yes** ☐ **No**
Company:	
Type (Plan A through J):	

Medicare Prescription Drug Plan	☐ **Yes** ☐ **No**
Company:	

Employer Retiree Health Plan	☐ **Yes** ☐ **No**
Company:	

Private Health Insurance	☐ **Yes** ☐ **No**
Company:	

Long Term Care Insurance	☐ **Yes** ☐ **No**
Company:	
Daily Benefit Amount:	
Length of Coverage:	

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)	☐ **Yes** ☐ **No**
Company:	
Type:	

Company:	
Type:	

Company:	
Type:	

WIFE:

MEDICARE

Traditional Medicare Fee-For-Service	☐ **Yes** ☐ **No**
Or	
Medicare HMO, PSO, PPO, or Private Pay Plan	☐ **Yes** ☐ **No**
Company:	

Medicare Supplement ("Medigap")	☐ **Yes** ☐ **No**
Company:	
Type (Plan A through J):	

Medicare Prescription Drug Plan	☐ **Yes** ☐ **No**
Company:	

Employer Retiree Health Plan	☐ **Yes** ☐ **No**
Company:	

Private Health Insurance	☐ **Yes** ☐ **No**
Company:	

Long Term Care Insurance	☐ **Yes** ☐ **No**
Company:	
Daily Benefit Amount:	
Length of Coverage:	

Other Type (Cancer, Accidental Death, Hospital Supplement, etc.)	☐ **Yes** ☐ **No**
Company:	
Type:	
Company:	
Type:	
Company:	
Type:	

6. MONTHLY EXPENSES:

ITEM	AMOUNT
Property Tax	$
Home maintenance and upkeep	$
Homeowners Insurance	$
Utilities (gas, electric, water & sewer, security)	$
Residential Facility	$
Private Health Care Services	$
Telephone	$
Cable Television	$
Auto Operation (gas and maintenance)	$
Auto Insurance	$
Clothing	$
Groceries and Other Household	$
Hair Cuts, Personal Grooming	$
Laundry and Dry Cleaning	$
Checking Account Charges/Bank Fees	$
Newspapers and Magazines	$
Recreation, Vacation, Entertainment	$
Health Insurance (such as Medicare Supplement)	$
Unreimbursed Medical Expense (such as drugs)	$
Life Insurance	$
Charitable Contributions	$
Other:	$
Other:	$
TOTAL MONTHLY EXPENSES:	$

Anticipated maintenance needs to homestead (example: roof, windows, painting, foundation repair, driveway, etc.)

ITEM	COST
	$
	$
	$
	$
	$
	$

7. MONEY YOU OWE:

CREDITOR'S NAME	AMOUNT OWED
	$
	$
	$
	$
	$
	$
	$
TOTAL:	$

8. PUBLIC BENEFITS and COMMUNITY SERVICES:

In addition to Social Security and Medicare, are you receiving any other forms of assistance, whether from the government, charitable organizations or churches, or volunteer organizations? Examples include: Veterans benefits, Section 8 housing and other subsidized housing, Medicaid, TennCare, CHAMPUS, TRICARE for Life, Meals-on-Wheels, subsidized regional transportation services, adult day care, support group services, property tax relief, home weatherization, and drug company discount card programs.

☐ **Yes** ☐ **No**

If yes, please list them below:

PROVIDER	FORM OF ASSISTANCE

9. GIFTS and TRANSFERS:

Have you made any gifts or transfers, greater than $500.00 to any individuals or to a trust within the last 60 months (5 years)? ☐ **Yes** ☐ **No**

If yes, please furnish the indicated information for each gift or transfer:

To Whom:	**To Whom:**
Date of Gift:	**Date of Gift:**
Item:	**Item:**
Value: $	**Value:** $
To Whom:	**To Whom:**
Date of Gift:	**Date of Gift:**
Item:	**Item:**
Value: $	**Value:** $

10. ESTATE PLANNING:

Please check the box that applies. Please bring existing documents with you to our meeting.

Do you have any of the following documents?	Husband	Wife
Durable Power of Attorney	☐ Yes ☐ No	☐ Yes ☐ No
Health Care Power of Attorney	☐ Yes ☐ No	☐ Yes ☐ No
Living Will	☐ Yes ☐ No	☐ Yes ☐ No
Will	☐ Yes ☐ No	☐ Yes ☐ No
Revocable Living Trust	☐ Yes ☐ No	☐ Yes ☐ No

Please provide the remaining information below only if the above documents are not in place or you want to make changes to these documents in our planning process.

There is a section to be completed for each of you (Husband and Wife).

Note: Please read all of the choices before selecting one. (If you aren't sure what you want to do, you don't have to make any choices right now.) We will discuss your choices at our meeting.

HUSBAND:

Upon my death, I want to give:

☐	Everything to my wife, if she survives me, otherwise to my children in equal shares
OR Alternative #1	
☐	Everything to my children in equal shares, but in trust for any child (or a child of a deceased child) who has not reached the age of
OR Alternative #2	
☐	Everything to my children and to my deceased spouse's children in equal shares
OR Alternative #3	
☐	I want to make bequests different from those above:

Do you want to leave any specific money or property to any individual or to a charity?

BENEFICIARY	ITEM/AMOUNT

WHO DO YOU WANT TO NAME AS THE EXECUTOR OF YOUR ESTATE?
(Spouses normally name each other first.) **(Please indicate your relationship to person you appoint.)**

	Husband:	Wife:
1)		
2)		
3)		

WHO DO YOU WANT TO NAME AS GUARDIANS OF YOUR MINOR CHILDREN (if applicable)? (Two persons can serve together as long as they are married.) **(Please indicate your relationship to person you appoint.)**

	Husband:	Wife:
1)		
2)		
3)		

WHO DO YOU WANT TO NAME AS AGENT ON YOUR BUSINESS POWER OF ATTORNEY? (Spouses normally name each other first. This Power of Attorney gives the person(s) you name the power to sign your name if you are not able to do so. For instance, it can be used to sign a deed or a tax return, or to make gifts of your property.) **(Please indicate your relationship to person you appoint.)**

	Husband:	Wife:
1)		
2)		
3)		

WHO DO YOU WANT TO NAME AS AGENT ON YOUR MEDICAL POWER OF ATTORNEY? (Spouses normally name each other first.) **(Please indicate your relationship to person you appoint.)**

	Husband:	Wife:
1)		
Address:		
Phone:		
2)		
Address:		
Phone:		
3)		
Address:		
Phone:		

Where do you plan to keep your original documents?

Briefly describe how you would like the HUSBAND's estate to be distributed at his death:

Briefly describe how you would like the WIFE's estate to be distributed at her death: