



Steven A. Early, J.D., CFP®
Attorney At Law

26 Main St.
Colleyville, TX 76034
(817) 605-8880 • Fax (817) 605-8882
steve@lawyerearly.com

MEDICAID PLANNING FORM –INDIVIDUAL (V2)

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

Name (First, Middle, Last): _____

Name you prefer to be called: _____

Date of Birth: _____

Place of Birth: _____

SSN: _____ **Medicare Number:** _____

Marital Status: Single Divorced Widowed Separated

Yes No

Full Name:

Date of Birth:

Date of Death:

Served during time of war? Yes No

Former Spouse a Veteran?

If yes, service dates:

Branch of Service:

Date of Marriage:

City/State of Marriage:

Marriage ended with death of spouse: Yes No

Home Address: _____

Home City, State, Zip: _____

County of Residence: _____ **US Citizen?** Yes No

Home Phone: _____ **Cell Phone:** _____

Home Email: _____

Name/Relationship:

Contact Information (if not you, **Phone:**
who should we contact for
appointments, information, etc.):

Address:

CHILDREN:

1) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Your child by birth/adoption <input type="checkbox"/> Previous spouse's child by birth/adoption	<input type="checkbox"/> Child taken into home (not yours by birth/adoption)
<input type="checkbox"/> Deceased		
Child's Phone:		# Of Children

2) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Your child by birth/adoption <input type="checkbox"/> Previous spouse's child by birth/adoption	<input type="checkbox"/> Child taken into home (not yours by birth/adoption)
<input type="checkbox"/> Deceased		
Child's Phone:		# Of Children

3) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Your child by birth/adoption <input type="checkbox"/> Previous spouse's child by birth/adoption	<input type="checkbox"/> Child taken into home (not yours by birth/adoption)
<input type="checkbox"/> Deceased		
Child's Phone:		# Of Children

4) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Your child by birth/adoption <input type="checkbox"/> Previous spouse's child by birth/adoption	
<input type="checkbox"/> Deceased	<input type="checkbox"/> Child taken into home (not yours by birth/adoption)	
Child's Phone:	# Of Children	

5) Child's Full Legal Name:	<input type="checkbox"/> Male / <input type="checkbox"/> Female	Birthdate:
Child's Address, City, State, Zip:	<input type="checkbox"/> Your child by birth/adoption <input type="checkbox"/> Previous spouse's child by birth/adoption	
<input type="checkbox"/> Deceased	<input type="checkbox"/> 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. RESOURCES:

Monthly Income

(Do not list interest or dividend income)

SOURCE	
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:	\$		

Other Assets/Life Insurance/Etc.

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

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

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Name of Company:	
Value:	\$
How is it titled?:	

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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?:	

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

Funeral/Burial

Do you have prepaid funeral or burial? Yes No

If yes, describe arrangements:

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Other Health Insurance:

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

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:

6. 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

7. 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: \$

8. 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?	
Durable Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Power of Attorney	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

WHO DO YOU WANT TO NAME AS THE EXECUTOR OF YOUR ESTATE?

Name(s)

Relationship

1) _____

2) _____

3) _____

WHO DO YOU WANT TO NAME AS THE TRUSTEE OF YOUR ACCOUNT(S)?

Name(s)

Relationship

1) _____

2) _____

3) _____

WHO DO YOU WANT TO NAME AS AGENT ON YOUR BUSINESS POWER OF ATTORNEY? (This Power of Attorney gives the person or persons 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.)

Name(s)

Relationship

1) _____

2) _____

3) _____

WHO DO YOU WANT TO NAME AS AGENT ON YOUR MEDICAL POWER OF ATTORNEY?

Name(s)

Relationship

1) _____

Address: _____

Phone: _____

2) _____

Address: _____

Phone: _____

3) _____

Address: _____

Phone: _____