LINDE LEGAL
attorneys at law

MEDICAID PLANNING QUESTIONNAIRE

Please complete the following questionnaire to the best of your ability. Please do not be concerned if you are not able to answer all questions. During our initial meeting we will review all information requested, and help you fill in any necessary information. This information is to assist us in making the appropriate recommendations for your planning based on your unique circumstances. Please mark N/A if the question does not apply to you. Please provide the information of the person for whom planning is being implemented (i.e. the Client).

Please be assured that all information provided shall be kept confidential in accordance with the attorney/ client privilege as required by the Rules Regulating The Florida Bar, Chapter 4. Rules of Professional Conduct.

A. PERSONAL DATA

APPLICANT

NAME _____

HOME ADDRESS/ FACILITY _____

_____

TELEPHONE _____

E-MAIL ADDRESS _____

BIRTHDATE _____

PLACE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

U.S. CITIZEN ☐ **YES** ☐ **NO**

VETERAN ☐ **YES** ☐ **NO**

B. MEDICAL INFORMATION OF APPLICANT

Diagnosis: _____
Treating physician: _____
Address: _____
If Applicant is currently placed/living in health facility: _____
Name of Facility: _____
Address of Facility: _____
Type of Facility (i.e. Assisted Living Facility/Nursing Home): _____
Date of Admission: _____
Was placement into facility after hospital stay: _____

C. FAMILY MEMBERS

Name: _____
Relationship: _____
Address: _____
Phone Number(s): _____
E-mail: _____

Name: _____
Relationship: _____
Address: _____
Phone Number(s): _____
E-mail: _____

Name: _____
Relationship: _____
Address: _____
Phone Number(s): _____
E-mail: _____

Name: _____

Relationship: _____

Address: _____

Phone Number(s): _____

E-mail: _____

D. MONTHLY INCOME FOR APPLICANT

Please provide the monthly income the Applicant is receiving.

INCOME	APPLICANT
SOCIAL SECURITY	
PENSION(S) **SOURCE, AMOUNT, & BENEFICIARY, IF APPLICABLE**	
STOCK(S)/DIVIDENDS	

BOND(S)	
CD(S)	
ANNUITY(IES) SOURCE, AMOUNT, & MANDATORY MINIMUM REQUIREMENT	
RENTAL INCOME	
OTHER INCOME *(ChildSupport, Unemployment, 401K, Gifts, etc.)*	

E. ASSETS FOR APPLICANT

ASSET	APPLICANT	JOINT ACCOUNTS
BANK ACCOUNTS **CHECKING** **SAVINGS**		
STOCK(S)		
BOND(S)		
CD(S)		
MUTUAL FUNDS		
ANNUITY(IES)		
IRA ACCOUNT(S)		

F. REAL ESTATE

i. HOMESTEAD

Homeowner(s): _____
Address: _____
Mortgage: _____
Value of Home: _____
Condo Association Fees: _____
Homeowners Association Fees: _____
Property Taxes: _____

ii. OTHER REAL PROPERTY

Homeowner(s): _____
Address: _____
Mortgage: _____
Value of Home: _____
Rental Income: _____
Condo Association Fees: _____
Homeowners Association Fees: _____
Property Taxes: _____

G. VEHICLE

Year: _____
Make: _____
Model: _____
Own ☐ Lease ☐
If lease, amount of monthly payment: _____
Automobile Insurance (Source and Payment): _____

H. INSURANCE

i. HEALTH INSURANCE

a. **Applicant**

Insured: _____

Source: _____

Premium: _____

Supplemental Insurance: _____

ii. LONG TERM CARE INSURANCE (LTCi)

a. **Applicant***

Source: _____

Daily Benefit: _____

**If Applicant has LTCi please provide our office with a copy of the policy.*

iii. LIFE INSURANCE

a. **Applicant**

Source: _____

Owner: _____

Beneficiary: _____

Face Value: _____

Cash Value: _____

Daily Benefit: _____

I. BURIAL INFORMATION

Do you own burial plots? Yes ☐ No ☐

Do you have any burial contracts and/or pre-paid funeral arrangements? Yes ☐ No ☐

Do you have a separate bank account for burial funds? Yes ☐ No ☐

J. GIFTS

Have you made any gifts within the last FIVE (5) years over $1,000? Yes ☐ No ☐

If you answered "Yes", please specify below:

Recipient/Beneficiary: _____
Year: _____
Amount: _____

Recipient/Beneficiary: _____
Year: _____
Amount: _____

Recipient/Beneficiary: _____
Year: _____
Amount: _____

K. INHERITANCE(S)

Are you expected to receive an inheritance from any trust(s)?

Source: _____
Amount: _____
Distribution (when and how you will receive): _____

Source: _____
Amount: _____
Distribution (when and how you will receive): _____

L. ACKNOWLEDGEMENT

The underigned hereby represents to Linde Legal, PLLC that the information contained in this Medicaid Questionnaire is accurate and complete, and to the best of his/her knowledge, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. The undersigned understands that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Any changes in the applicant's circumstances that might affect Medicaid eligibility must be reported as soon as possible.

Signature of Client or Client Representative:

_____ _____

Name Date