Reset Checkboxes

MEDICAID PLANNING CLIENT QUESTIONNAIRE

Welcome to Hawkins Elder Law! To best serve you, we need to know as much about the matter as possible. Please answer the following questions before our initial meeting:

1. **How did you hear about Hawkins Elder Law?** _____

2. **Information about person completing this Questionnaire:**

   Full Name: _____

   Address: _____

   E-mail Address: _____ Best Telephone #: _____

   Relationship to person described in #3 below: _____

   Most people prefer to be addressed by gender-specific (such as he, him, his, and himself, or she, her, hers, and herself) or general-neutral pronouns (such as co, cos, and coself, or they, them, their, theirs, and themself). Which pronouns do you prefer? ☐ Male ☐ Female ☐ Other

   If you prefer other pronouns, what are they? _____

3. **Information about the person who may need nursing home care or in-home care:**

   Full Name: _____

   Date of Birth: _____ Social Security Number: _____

   Please don't email Social Security information for security reasons. Please give us this information by phone.

   Currently in Nursing Home? ☐Yes ☐No

   Name of Nursing Home _____

   Nursing Home's daily rate/cost _____

   Address (before nursing home): _____

   Date moved into home at this address: _____

   Highest Level of Education (for example: graduated high school) _____

   Veteran of the armed forces? ☐Yes ☐No If yes, what branch? _____

   Does the person have a power of attorney? ☐Yes ☐No

   If yes, who has authority under the POA _____

Does the person have a court-appointed guardian? ☐Yes ☐No

If yes, who is the Guardian? _____

If yes, in what city or town in is the court located? _____

Is the person a member of a federally recognized Indian Tribe? ☐Yes ☐No

Does the person identify with a particular race or ethnicity? ☐Yes ☐No

If yes, what is the race or ethnicity? _____

Within the last 24 months, has the person had an injury or accident that might result in a lawsuit by or against the person? ☐Yes ☐No

(Only if currently married) Has the person ever been in a hospital, nursing home, rehab center, or a combination of these types of facilities for a continuous period of 30 days or more (even if long ago)? ☐Yes ☐No

If the answer is yes, what the first date of that stay? _____

Has the person previously ever received public assistance in Indiana or any other state? (Medicaid, food stamps, etc)? ☐Yes ☐No

Does the person have Long Term Care Insurance? ☐Yes ☐No

If yes, name of insurance company: _____

Does the person have a pre-paid funeral? ☐Yes ☐No

If yes, name of funeral home: _____

What is the marital status of the person?

☐ Single (never married)

☐Married (Go to #4)

☐ Widowed – Name and date of death of each deceased spouse:

Name: _____ Date of death: _____

Name: _____ Date of death: _____

Name: _____ Date of death: _____

☐Divorced – Name of each ex-spouse and date of divorce:

Name: _____ Date of divorce: _____

Name: _____ Date of divorce: _____

Name: _____ Date of divorce: _____

4. Current Spouse of the person (if applicable):

Full Name: _____Date of Marriage:_____

Address: _____

E-mail Address: _____ Best Telephone #: _____

5. Children of the person needing nursing home care:

Full Name	E-mail Address:	Mailing Address	Best Telephone #:

Are any of the person's children disabled? ☐Yes ☐No Deceased? ☐Yes ☐No

Names of disabled or deceased children: _____

6. Income Sources of the person needing care (check all that apply):

☐ Social Security Amount per month: _____

☐ Pension Amount per month: _____ Company: _____

☐ PERF Amount per month: _____ Employer: _____

☐ VA Benefits Type: _____ Amount per month: _____

☐ Farm Income Amount per month: _____ Farmer: _____

☐ Other Amount per month: _____ Describe: _____

7. Income Sources of Spouse, if applicable (check all that apply):

☐ Social Security Amount per month: _____

☐ Pension Amount per month: _____ Company: _____

☐ PERF Amount per month: _____ Employer: _____

☐ VA Benefits Type: _____ Amount per month: _____

☐ Farm Income Amount per month: _____ Farmer: _____

☐ Other Amount per month: _____ Describe: _____

8. Resources/Assets of the person and spouse, if applicable:

(Feel Free to add pages if necessary)

Type of Asset	Brief Description	Approximate Value
☐ Real Estate		
☐ Bank Accounts/CDs		
☐ Investments		
☐ IRA, 401(k), etc.		

Type of Asset	Brief Description	Approximate Value
☐ Annuities		
☐ Stocks		
☐ Savings Bonds		
☐ Cash (Coins or Currency)		
☐ Life Insurance		
☐ Vehicles		

Type of Asset	Brief Description	Approximate Value
☐ Expected Inheritance		

9. Gifts/Transfers: Within the past five years, has the person needing care or that person's spouse made any gifts or transfers to any other person, for any reason? Examples include gifts of cash, by check, transfers of any interest in real estate, giving someone a vehicle or adding someone to the title of a vehicle etc.

☐Yes ☐No

Type of Gift/Transfer	Date of Gift/Transfer	Gift/Transfer Value
Example: Cash gift	*April 2019*	*$1,000.00*

10. Are there any unpaid loans the person or the spouse has made to anyone? ☐Yes ☐No

If yes, describe: _____

11. Please use this space to list any specific questions or topics you would like to discuss with the attorney or to elaborate on any answers given above.