

HICKMAN♦MENASHE  
ATTORNEYS AT LAW  
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**CONFIDENTIAL MEDICAID PLANNING  
QUESTIONNAIRE FOR A MARRIED APPLICANT**

*Please complete this questionnaire to the best of your ability and bring it with you to our first meeting where we will go over it together. **Do not delay this important planning because you are unable to answer each question.** Simply note any questions you may have and we will be happy to help you when we meet. We look forward to serving your Medicaid planning needs.*

**PERSONAL INFORMATION**

**INFORMATION FOR POTENTIAL MEDICAID APPLICANT**

Full Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Preferred Phone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Yes, It Is Okay to Communicate with Me Via E-mail

Birth Date: \_\_\_\_\_ US Citizen? Yes  No  If No, Provide Status: \_\_\_\_\_

Veteran? Yes  No  If Yes, Branch and Years of Service: \_\_\_\_\_

If Current Address is a **Care Facility**, Please Answer the Additional Questions Below:

Name of Facility: \_\_\_\_\_

This Facility is: An Assisted Living Facility  A Nursing Home  An Adult Family Home

Date of Admittance: \_\_\_\_\_ Current Source of Payment for Care: \_\_\_\_\_

This Facility Accepts Medicaid: Yes  No  I'm Unsure

**INFORMATION FOR SPOUSE OF POTENTIAL MEDICAID APPLICANT**

Full Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

County of Residence: \_\_\_\_\_ Preferred Phone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Yes, It Is Okay to Communicate with Me Via E-mail

Birth Date: \_\_\_\_\_ US Citizen? Yes  No  If No, Provide Status: \_\_\_\_\_

Veteran? Yes  No  If Yes, Branch and Years of Service: \_\_\_\_\_

**CHILDREN**

*Attach additional sheets if necessary.*

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This Child is Deceased: Yes  No

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This Child is Deceased: Yes  No

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This Child is Deceased: Yes  No

**ASSETS**

*For the assets below, please feel free to use an approximate value.*

**REAL ESTATE**

Address: \_\_\_\_\_

Name(s) of Owner(s): \_\_\_\_\_

Value: \_\_\_\_\_ This Property Is: A Primary Residence  An Investment  A Vacation Home

Address: \_\_\_\_\_

Name(s) of Owner(s): \_\_\_\_\_

Value: \_\_\_\_\_ This Property Is: A Primary Residence  An Investment  A Vacation Home

**CHECKING AND SAVINGS ACCOUNTS**

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_ This Account is Jointly Held: Yes  No

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_ This Account is Jointly Held: Yes  No

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_ This Account is Jointly Held: Yes  No

**INVESTMENT ACCOUNTS** (Stocks, Bonds, Mutual Funds, CDs)

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_ This Account is Jointly Held: Yes  No

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_ This Account is Jointly Held: Yes  No

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_ This Account is Jointly Held: Yes  No

**RETIREMENT ACCOUNTS** (IRAs, 401(K)s, Pensions)

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_

**ANNUITIES AND LIFE INSURANCE**

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_

Type of Account: \_\_\_\_\_ Name of Institution That Holds Account: \_\_\_\_\_

Value: \_\_\_\_\_

**OTHER ASSETS** (Antiques, Art, Burial Plots, etc.)

Type of Asset: \_\_\_\_\_ Value: \_\_\_\_\_

Type of Asset: \_\_\_\_\_ Value: \_\_\_\_\_

Type of Asset: \_\_\_\_\_ Value: \_\_\_\_\_

**INCOME**

**MEDICAID APPLICANT**

Type of Income: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_

Type of Income: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_

Type of Income: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_

**SPOUSE OF MEDICAID APPLICANT**

Type of Income: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_

Type of Income: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_

Type of Income: \_\_\_\_\_ Monthly Amount: \$ \_\_\_\_\_

**LIVING EXPENSES**

*For all expenses below, please indicate the **monthly** amount of each expense.*

**CURRENT EXPENSES**

Rent or Mortgage Payment: \$ \_\_\_\_\_

Homeowners Insurance: \$ \_\_\_\_\_

Water, Sewer, and Garbage: \$ \_\_\_\_\_

Heat and Electric: \$ \_\_\_\_\_

Condominium/ Homeowners Association Fees: \$ \_\_\_\_\_

**IF POTENTIAL MEDICAID APPLICANT IS CURRENTLY IN A CARE FACILITY**

Facility Expenses: \$ \_\_\_\_\_

Prescription Expenses: \$ \_\_\_\_\_

Utility Expenses (Phone, Cable TV, Etc.): \$ \_\_\_\_\_

**DEBTS**

Total Unpaid Credit Card Debt: \$ \_\_\_\_\_

Total Mortgage: \$ \_\_\_\_\_

Total Unpaid Medical Bills (from last three months): \$ \_\_\_\_\_

Type of Other Outstanding Debt: \_\_\_\_\_ Amount Owed: \$ \_\_\_\_\_

Type of Other Outstanding Debt: \_\_\_\_\_ Amount Owed: \$ \_\_\_\_\_

**GIFTS**

*Please indicate any gifts you have made **within the last five years.**  
The gift can be of any asset, including personal property, cash, or a vehicle.*

Date of Gift: \_\_\_\_\_ Asset Gifted: \_\_\_\_\_

Recipient of Gift: \_\_\_\_\_ Relationship to Recipient: \_\_\_\_\_

Value of Gift: \_\_\_\_\_ I Filed a Gift Tax Return for This Gift: Yes  No

Date of Gift: \_\_\_\_\_ Asset Gifted: \_\_\_\_\_

Recipient of Gift: \_\_\_\_\_ Relationship to Recipient: \_\_\_\_\_

Value of Gift: \_\_\_\_\_ I Filed a Gift Tax Return for This Gift: Yes  No

Date of Gift: \_\_\_\_\_ Asset Gifted: \_\_\_\_\_

Recipient of Gift: \_\_\_\_\_ Relationship to Recipient: \_\_\_\_\_

Value of Gift: \_\_\_\_\_ I Filed a Gift Tax Return for This Gift: Yes  No

**PRIOR ESTATE PLANNING DOCUMENTS**

*Please check all those that apply. If you do have any of the documents listed below, please bring a copy to your meeting.*

**Medicaid Applicant**

**Spouse of Medicaid Applicant**

- |   |                       |   |                       |
|---|-----------------------|---|-----------------------|
| Wills (and Any Codicils)                    | <input type="radio"/> | Wills (and Any Codicils)                    | <input type="radio"/> |
| Community Property Agreement                | <input type="radio"/> | Community Property Agreement                | <input type="radio"/> |
| Health Care Directive/ Living Will          | <input type="radio"/> | Health Care Directive/ Living Will          | <input type="radio"/> |
| Special Needs Trust                         | <input type="radio"/> | Special Needs Trust                         | <input type="radio"/> |
| Durable Power of Attorney (For Finances)    | <input type="radio"/> | Durable Power of Attorney (For Finances)    | <input type="radio"/> |
| Durable Power of Attorney (For Health Care) | <input type="radio"/> | Durable Power of Attorney (For Health Care) | <input type="radio"/> |
| Revocable Living Trust/ Other Trust         | <input type="radio"/> | Revocable Living Trust/ Other Trust         | <input type="radio"/> |
| Mental Health Advance Directive             | <input type="radio"/> | Mental Health Advance Directive             | <input type="radio"/> |

**MISCELLANEOUS**

*If you answer yes to the questions below, you do not need to provide any additional documentation. We ask these questions to know whether we should discuss any of these items further during our meeting.*

Has the Medicaid Applicant and/ or Spouse Prepaid for Burial and Funeral Arrangements? Yes  No

