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**CONFIDENTIAL MEDICAID PLANNING
QUESTIONNAIRE FOR A SINGLE 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 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: _____

Previously Married? Yes No If Yes, Previous Marriage Ended By: Death Divorce Annulment

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

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

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.

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

Do Any Children of the Medicaid Applicant Have Mental or Physical Disabilities? Yes No

Do Any Children of the Medicaid Applicant Receive Social Security Income or SSDI? Yes No

Has a Child Been Living with the Medicaid Applicant and Providing Caregiving Services? Yes No

