PETROSEWICZ LAW FIRM, P.C.
PROTECTING OUR CLIENTS AND THEIR LEGACY SINCE 1991
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MEDICAID QUESTIONNAIRE

Date Completed: _____

1 PERSONAL INFORMATION

NOTICE OF CONFIDENTIALITY:
THE INFORMATION IN THIS DOCUMENT IS SUBJECT TO THE ATTORNEY-CLIENT PRIVILEGE, AS PROVIDED IN THE TEXAS RULES OF EVIDENCE. THE CONTENTS OF THIS DOCUMENT CONSTITUTE ATTORNEY WORK PRODUCT. THE CONTENTS OF THIS DOCUMENT ARE CONFIDENTIAL AND ARE NOT TO BE DISCLOSED TO THIRD PERSONS OTHER THAN THOSE TO WHOM DISCLOSURE IS MADE IN FURTHERANCE OF THE RENDITION OF PROFESSIONAL LEGAL SERVICES.

Name: _____
Last First Middle Maiden

DOB: _____ SSN: _____

US Citizen: ☐ YES ☐ NO Place of Birth: _____

Veteran: ☐ YES ☐ NO If yes, dates of services: _____

Living Arrangement:
___ own home ___ apartment/rent house ___ household of another
___ nursing home (date: _____) ___ assisted living/personal care home (date: _____)

Home Address: _____
City, State, Zip: _____
County: _____
Email: _____ Phone: _____

Name of Spouse: _____
Last First Middle Maiden

DOB: _____ SSN: _____

US Citizen: ☐ YES ☐ NO Place of Birth: _____

Veteran: ☐ YES ☐ NO If yes, dates of Service: _____

Date of Marriage: _____ Date of Death, if deceased: _____

Living Arrangement:
___ own home ___ apartment/rent house ___ household of another
___ nursing home (date: _____) ___ assisted living/personal care home (date: _____)

Home Address: _____
City, State, Zip: _____
County: _____
Email: _____ Phone: _____

2 CHILDREN'S INFORMATION

Child #1 *Special Needs:* ☐ Medical ☐ Educational ☐ Financial

Full Legal Name: _____

Home Address: _____

City, State, Zip: _____

Email: _____ Phone: _____

Date of Birth (Month/Day/Year) _____

☐ Married ☐ Divorced ☐ Widowed ☐ Single Child #1's Spouse: _____

Child #1's Children (Name and Date of Birth)

_____ _____ _____

Child #2 *Special Needs:* ☐ Medical ☐ Educational ☐ Financial

Full Legal Name: _____

Home Address: _____

City, State, Zip: _____

Email: _____ Phone: _____

Date of Birth (Month/Day/Year) _____

☐ Married ☐ Divorced ☐ Widowed ☐ Single Child #2's Spouse: _____

Child #2's Children (Name and Date of Birth)

_____ _____ _____

Child #3 *Special Needs:* ☐ Medical ☐ Educational ☐ Financial

Full Legal Name: _____

Home Address: _____

City, State, Zip: _____

Email: _____ Phone: _____

Date of Birth (Month/Day/Year) _____

☐ Married ☐ Divorced ☐ Widowed ☐ Single Child #3's Spouse: _____

Child #3's Children (Name and Date of Birth)

_____ _____ _____

Child #4 *Special Needs:* ☐ Medical ☐ Educational ☐ Financial

Full Legal Name: _____

Home Address: _____

City, State, Zip: _____

Email: _____ Phone: _____

Date of Birth (Month/Day/Year) _____

☐ Married ☐ Divorced ☐ Widowed ☐ Single Child #3's Spouse: _____

Child #3's Children (Name and Date of Birth)

_____ _____ _____

For additional children, please duplicate/copy this page as needed

3 ADDITIONAL INFORMATION

Do you have a Court Appointed Guardian? Yes _____No _____
Does your spouse have a Court Appointed Guardian? Yes _____No _____

If Yes, please provide a copy of the Court Order and Letters of Guardianship.

Do you have a Will? Yes _____No _____
Does your spouse have a Will? Yes _____No _____

Do you have a Power of Attorney (for financial decisions)? Yes _____No _____
Does your spouse have a Power of Attorney? Yes _____No _____

Name of your Agent under a Power of Attorney, Guardian, or if neither, the person assisting you with financial, medical, and personal matters?_____

Address: _____

Email: _____ Phone:_____

Please provide a copy of all existing estate planning documents (Will, Power of Attorney, Medical Power of Attorney, HIPAA Authorization, Directive to Physicians, etc.).

Do you have Medicare Part A? Yes _____ No _____
Do you have Medicare Part B? Yes _____ No _____

Does your spouse have Medicare Part A? Yes _____ No _____
Does your spouse have Medicare Part B? Yes _____ No _____

Health Insurance:	Company	Monthly Premium
Your Medicare Supplement:		$
Spouse's Medicare Supplement:		$
Your Prescription Plan:		$
Spouse's Prescription Plan:		$
Other:		$
Other:		$

Medical Condition:

Your Diagnosis: _____
Spouse's Diagnosis: _____

Have you or your spouse ever been in one or more medical care facilities for a continuous period of 30 days or more? If so, please list the names of the facilities, and the dates at each facility:

_____
_____
_____
_____
_____
_____

4 ASSET INFORMATION – For You AND Your Spouse

If possible, please bring written verification of each asset with you to your appointment. Especially helpful are the last three financial statements for all accounts, life insurance policies, promissory notes, trust documents, deeds evidencing ownership of all real property, and oil/gas/mineral leases.

Checking Accounts:	Account No.	Name of Institution		Amount
Savings Accounts:	Account No.	Name of Institution		Amount
Certificates of Deposit:	Account No.	Name of Institution		Amount
Money Market Accounts:	Account No.	Name of Institution		Amount
IRAs:	Account No.	Name of Institution	Owner	Amount
Retirement Accounts: (401(k), 403(b), etc.)	Account No.	Name of Institution	Owner	Amount

Investment Accounts, Annuities: Account No. Name of Institution Amount

Savings Bonds: No. of Bonds Series Denomination Total Value

Certificated Stocks: No. of Shares Name of Company Total Value

Closed Accounts in Last 60 Months: Date Name of Institution Closing Balance

Authorized Signer on Other Accounts: Owner of Funds Name of Institution Amount

Safe Deposit Box Yes _____ No _____

Location:

Contents:

Patient Trust Fund at Nursing Facility: Yes _____ No _____

Amount:

Cash on Hand: Amount:

Life Insurance: Policy Number Name of Company Face Value Cash Value

Burial Spaces: Name of Cemetery Number of Spaces Value

Preneed Funeral Contract: Name of Funeral Home Purchaser/Owner Value

Is Someone Repaying You a Loan, Promissory, Or Mortgage Note: Date Name of Borrower Monthly Payment Balance

Trusts, Partnerships, Businesses, Other Entities: Date Name of Entity

Automobiles, Trucks, Boats, Recreational Vehicles: Year Make Model Value

Homestead, including Mobile Home: Address Amount of Land Value

Other Land, Lots, Houses (total or part ownership): Address Amount of Land Value

Oil, Gas, Mineral, Surface Rights: Description Producing or Non-Producing Value

Livestock, Poultry: Description Value

Work Equipment: Description Value

Ownership Interest in Anything Not Listed Above: Description Value

Have you transferred, deeded, sold, loaned, or given away any houses, lots, land, money, or anything else in the past 60 months? Yes _____ No _____

If Yes:

Item	Date of Transaction	To Whom?	Market Value	Value Received

Please provide written proof of the transfer, the value of the transferred asset and the date of the transfer.

5 INCOME INFORMATION – For You AND Your Spouse

If possible, please bring written verification of this year's gross and net income amounts, as well as proof of the amount and reason of all deductions from your and your spouse's income.

Social Security:	Claim No.	Gross Monthly Amount
Self:		
Spouse:		

VA Pension/Comp:	Claim No.	Gross Monthly Amount
Self:		
Spouse:		

Other Retirement:	Description	Gross Monthly Amount
Self:		
Self:		
Spouse:		
Spouse:		

RMDs from IRAs:	Description	Gross Monthly or Annual Amount
Self:		
Self:		
Spouse:		
Spouse:		

Earnings:	Description	Gross Monthly Amount
Self:		
Spouse:		

Rental/Lease Income:	Description	Gross Monthly Amount
Self:		
Spouse:		

Oil, Gas, Mineral Royalties:	Description	Gross Monthly Amount
Self:		
Spouse:		

Other Income:	Description	Gross Monthly Amount
Self:		
Spouse:		

What are your top 3 Concerns/Questions?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Did anyone refer you? If yes, who: _____

The undersigned affirms that the answers provided on this confidential Medicaid Questionnaire are accurate and complete, and that the Petrosewicz Law Firm, P.C. ("the Firm") will be relying on this information in its preparation and counseling regarding Medicaid planning, estate planning, and other legal matters if the undersigned becomes a client of the Firm. If the undersigned becomes a client of the Firm, any information that would render this information inaccurate or incomplete will be provided to the Firm in writing within ten (10) days of the date the undersigned becomes aware of the inaccuracy or incompleteness of it. No attorney client relationship has or will be established until an engagement letter has been executed.

Printed Name _____

Signature _____

Date _____