

121 FM 359 Rd., Richmond, TX 77406-2401

MEDICAID QUESTIONNAIRE

Date Completed: _____

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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: _____

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

Legal Name: _____

Home Address: _____

City, State, Zip: _____

Email: _____ Phone: _____

Date of Birth (Month/Day/Year) _____

☐ Married ☐ Divorced ☐ Widowed ☐ Single Child #4's Spouse: _____

Child #4's Children (Name and Date of Birth)

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

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:

Please provide written verification of each asset. 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 Location:	Yes _____	No _____
Contents:		

Patient Trust Fund at Nursing Facility:	Yes _____	No _____
Amount:		

Cash on Hand:	Amount:	
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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/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:	Date of	Market	Value
	Item	Transaction	To Whom?

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

Please provide 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 _____