MEDICAID INFORMATION FORM **Date: _____**

Applicant (*): _____

In order for us to properly assess your eligibility for Medicaid (or SSI), we must have **all** of the following information. If you do not understand any question, ask our attorney or legal assistant about it. In this form, the word "**Applicant**"(*****) refers to the person for whom Medicaid is to be sought.

1. Applicant (and Spouse if applicable)

	Applicant	Spouse
a. Full Name:	_____	_____
b. Other/Former Names:	_____	_____
c. U.S. Citizen:	Yes _____ No _____	Yes _____ No _____
d. If not citizen, legal aliens date of entry to U.S.:	_____	_____
e. Date of Birth:	_____	_____
f. Soc. Sec. No.	_____	_____
g. Residence Address:	_____	_____
	_____	_____
Phone:	_____	_____

2. Marital Information

a. Date and place of marriage: _____

b. Has Applicant ever been married before? ____ Yes ____ No [For each, complete:]

Applicant's former spouse: _____

How marriage ended: ____ death ____ divorce Date of death/divorce: _____

Applicant's former spouse: _____

How marriage ended: ____ death ____ divorce Date of death/divorce: _____

3. Applicant's Parents (if living)

	Father	Mother
a. Full Name:	_____	_____
b. Other/Former Names:	_____	_____
c. U.S. Citizen:	Yes _____ No _____	Yes _____ No _____
d. If not citizen, legal aliens date of entry to U.S.:	_____	_____
e. Date of Birth:	_____	_____
f. Residence Address:	_____	_____
	_____	_____
Phone:	_____	_____

4. Employment

a. Does **Applicant** work? Yes _____ No _____
If "Yes", employer: _____
Self-employed? Yes _____ No _____
Total wages (monthly) before deductions: $ _____ Paid how often? _____
If not employed, date and employer of last employment: _____

b. Does **Applicant's spouse** work? Yes _____ No _____
If "Yes", employer: _____
Self-employed? Yes _____ No _____
Total wages (monthly) before deductions: $ _____ Paid how often? _____
If not employed, date and employer of last employment: _____

5. Veteran Status

a. Is Applicant a veteran? Yes _____ No _____ Married to a veteran? Yes _____ No _____
b. Is Applicant a dependent of a **living** or **deceased** veteran? Yes _____ No _____
c. If answered "Yes" to any of above, complete the following:
Name of veteran: _____
Relationship to Applicant: _____
Veteran's Service No. or Claim No.: _____
Branch of Service: _____ Dates of Service: _____
d. Has Applicant ever applied for VA benefits under Veterans and Survivors Improvement Act? Yes ____ No ____
e. If Applicant in a nursing home, has Applicant ever applied for VA Aid & Attendance benefits? Yes ____ No ____

6. Physical/Mental Condition(s) (Diagnosis and Description)

a. Applicant: _____
_____
b. Spouse: _____
_____
c. What prescription medicines do you take?
Applicant: _____
_____
Spouse: _____
_____

7. Abilities and Disabilities

a. Are you able to sign your name without assistance?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
b. Are you able to sign your name with assistance?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
c. Are you able to read and understand what you read?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
d. Do you have trouble remembering friends, family members and events from long ago?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
e. Do you have trouble remembering things that happened recently?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

f. Do you have difficulty hearing?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

g. Do you have difficulty seeing?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

h. Do you require assistance with any of the following activities on a daily basis?
Eating: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Drinking: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Walking: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Bathing: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Toileting: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____
Dressing: Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

i. Are you able to keep your own checkbook and financial records without assistance?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

j. Do you generally know what assets (money, land, etc.) you own and what debts you owe?
Applicant: Yes _____ No _____ Spouse: Yes _____ No _____

k. Have you given anyone a written **power of attorney**? (If "yes" give name & address)
Applicant: Yes _____ No _____ To: _____
Agent's address: _____
Spouse: Yes _____ No _____ To: _____
Agent's address: _____

l. Does Applicant have a court-appointed **guardian or conservator**? Yes _____ No _____
Name: _____
Address: _____

m. Is Applicant the **beneficiary of a trust**? Yes _____ No _____
Trustee's name: _____
Address: _____

8. Physician(s)

Applicant #1: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____
Applicant #2: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Spouse #1: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____
Spouse #2: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

9. Applicant's Household Members

a. List members of Applicant's household. If Applicant in nursing facility, list people living in house prior to Applicant entering nursing facility:

Name	Age	Relationship to Applicant

_____
_____
_____
_____
_____

b. Is any **member of Applicant's family disabled**? Yes _____ No _____ If so:
Name/Age/Relationship to Applicant: _____
_____

10. Residence Details

a. Residence **owned** by Applicant? Yes _____ No _____ **(If "No", skip to # 11.)**
b. Type residence: Single family _____ Duplex _____ Other (# units) _____
c. How owned: Sole owner _____ Joint with spouse _____ Joint with others _____ Life Estate _____
d. Date purchased: _____ Purchase Price: $_____ Estimated market value: $_____
e. First mortgage (lender): _____
Balance owed: $ _____ Monthly payments: $_____
Second mortgage (lender): _____
Balance owed: $ _____ Monthly payments: $_____
f. Has a child lived in the residence with Applicant for at least 2 years? Yes _____ No _____
If so, has the child provided personal care and assistance to Applicant that might have kept Applicant out of nursing facility? Yes _____ No _____
Describe assistance: _____
g. If other owner is a sibling, has that sibling lived in the residence for at least one year?
Yes _____ No _____
Does that sibling have an equity interest in the home? Yes _____ No _____
h. Reverse Mortgage on property? Yes _____ No _____

11. Residence Rented

a. Residence rented? Yes _____ No _____ Monthly cost: $_____
b. Type of rental:
____ Single family house ____ Retirement Community ____ Assisted Living
____ Apartment ____ Senior Housing (Subsidized? Yes ____ No ____)

12. Long Term Care (Nursing Home)

a. Is Applicant or spouse in a nursing home?
Applicant: Yes ____ No ____ Spouse: Yes ____ No ____
b. If so, date of entry (continuous stay since entry): _____
c. Name of nursing facility: _____
Address: _____
Phone: _____
Administrator /contact person: _____
d. Does the facility accept Medicaid? Yes _____ No _____

13. Hospitalization(s)

a. Is Applicant or spouse in a hospital?

Applicant: Yes _____ No _____ Admission Date: ___________________________________

Hospital name/address: ____

Spouse: Yes ______ No ______ Admission Date: ____________________________________

Hospital name/address: ____

If so, for how long? ____

Reason for admission: ____

Convalescence in nursing home expected? Yes ______ No ______

If nursing home placement is expected, likely to later return home? Yes ______ No ______

b. Hospital admissions during last 3 years (hospital name / dates / reason):

Applicant: ____

____

Spouse: ____

____

14. Health and LTC Insurance

a. Does Applicant have **Medicare Part A**? Yes ____ No ____ **Part B**? Yes ____ No ____

Medicare Claim No.: ____

b. Does Applicant have **other health insurance** of any type? Yes ____ No ____

Company name: ____

Address: ____

Policy No.: ____________________________ Begin date: ___________ End date: _____________

Policy owner: __________________________ Relation to Applicant: _________________________

Type policy: Cancer _____ Medicare Supplement _____ Hospital Indemnity _____

Accident _____ Intensive Care _____ Long Term Care ______

Other (explain) ____

Company name: ____

Address: ____

Policy No.: ____________________________ Begin date: ___________ End date: _____________

Policy owner: __________________________ Relation to Applicant: _________________________

Type policy: Cancer _____ Medicare Supplement _____ Hospital Indemnity _____

Accident _____ Intensive Care _____ Long Term Care ______

Other (explain) ____

Company name: ____

Address: ____

Policy No.: ____________________________ Begin date: ___________ End date: _____________

Policy owner: __________________________ Relation to Applicant: _________________________

Type policy: Cancer _____ Medicare Supplement _____ Hospital Indemnity _____

Accident _____ Intensive Care _____ Long Term Care ______

Other (explain) ____

15. Income

a. Monthly Income

Source (describe):	Whose "Name on Check" (Applicant)	(Spouse)	Terminate @ death? Y / N
Social Security _____	$_____	$_____	_____
SSI _____	$_____	$_____	_____
Railroad Retirement _____	$_____	$_____	_____
State Retirement _____	$_____	$_____	_____
Private Retirement (IRA, etc.) _____	$_____	$_____	_____
Pension (_____)	$_____	$_____	_____
Rental Income (_____)	$_____	$_____	_____
Interest Income (_____)	$_____	$_____	_____
Alimony (_____)	$_____	$_____	_____
Child Support (_____)	$_____	$_____	_____
Other (_____)	$_____	$_____	_____
Totals:	$_____	$_____	

b. Did Applicant or Spouse file income tax return last year:
Federal: Yes _____ No _____ State: Yes _____ No _____

16. Financial Information

Please supply information pertaining to real property, bank and savings accounts, retirement plans, insurance and annuity policies, personal property, liabilities, income and expenses on the separate **FINANCIAL INFORMATION** schedule.

17. Other Property Interests (Liberalized Rules)

a. Does Applicant own the following? (indicate **Applicant**, **Spouse** or **Both** and describe):
(i) Life estate in any property? _____
(ii) Remainder interest in property? _____
(iii) Undivided heir interest in property? _____
(iv) 16th Section leasehold? _____
(v) Mineral or timber rights not in production? _____
(vi) Income producing property? _____
(vii) Promissory notes from others? _____
(viii) Automobiles? (give Make/Model/Year/Value) _____
_____
(ix) Personal property up to $5,000 equity value? _____
(x) Cash value life insurance policies? _____
(xi) Assets essential for self-support? _____

b. Does Applicant or Spouse own **burial spaces** for family members? Yes _____ No _____
Name & location of cemetery: _____ No. gravesites owned: _____
All spaces for Applicant's family? Yes _____ No _____

c. Are **burial funds** set aside? **Applicant**: Yes ____ No ____ **Spouse**: Yes ____ No ____
How are funds set up? Cash ____ Burial contract or insurance ____ Other _____
Value or Amount of funds: Applicant $ _____ Spouse $ _____
Can funds be cashed in? **Applicant**: Yes ____ No ____ **Spouse**: Yes ____ No ____

18. Gifts

a. Has Applicant made any gifts of money or property during last five years? Yes _____ No _____

b. Applicant made any transfers to or from a trust within the last five years? Yes _____ No _____

c. Details:

Recipient	Amount/Type Property	Date of Gift

d. Gift tax returns filed? Yes ____ No ____ If so, what years? _____

19. Most Trusted Child(ren)

a. Does Applicant or Spouse rely on one or more children for financial or personal assistance?
Yes _____ No _____ If so, who has assistance responsibilities?
(i) For Applicant: _____
(ii) For Spouse:_____

20. Problem Family Members

a. Is any family member not to be relied upon to help with management or other need of Applicant or Spouse? Yes _____ No _____

b. If so, name & relationship to Applicant:_____
_____

c. Why?_____
_____

21. Person(s) supplying answers to these questions:

a. Name _____

b. If not Applicant, relationship to Applicant: _____

NOTES:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____