CRISIS MEDICAID PLANNING QUESTIONNAIRE – SINGLE PERSON

Attorney or Advisor's Contact Information

Name:	
Address:	
City, State, Zip:	
Telephone:	
Facsimile:	
E-Mail:	

A. PERSONAL DATA

Client Full Name_____

Street Address_____

City_____ State_____ Zip_____

Birth Date _____

U. S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐ Surviving Spouse of Veteran? Yes No

B. MEDICAL DATA

Diagnosis _____

Prognosis _____

Course of Treatment _____

Where Individual Currently Resides _____

If individual has already entered a nursing home, please indicate the name of the nursing home and the first date entered on a continuous basis _____

C. MONTHLY INCOME

	Monthly Income
Social Security Benefit	$_____
Retirement Benefit (Gross)	$_____
VA Disability Benefit	$_____
Annuity Income	$_____
Rental Income	$_____
Total Monthly Income	$_____

Do not include interest and dividend income on this form.

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

D. MONTHLY COST OF NURSING HOME

$_____	Monthly Nursing Home Cost
$_____	Health Insurance Premiums
$_____	Medicare Supplemental Insurance Premiums
$_____	Monthly Incidental Cost
$_____	Monthly Prescription Cost
$_____	Monthly Other Cost
$_____	**Total Monthly Costs**

The nursing home is paid through _____(month/year).

If the nursing home facility is located in **New Hampshire**, **Kansas**, **Ohio**, or **Pennsylvania** AFFC will require the nursing home facility's Medicaid per diem rate to develop the appropriate Medicaid Compliant Annuity Plan.

As such, if applicable, please provide the Medicaid per diem rate: $ _____

E. ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Value	Liability
AUTOMOBILE		
ADDITIONAL AUTOMOBILE		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MONEY MARKET ACCOUNT		
CERTIFICIATES OF DEPOSIT		
RESIDENCE		
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
IRA		
OTHER REAL ESTATE		
NURSING HOME DEPOSIT		
OTHER		
OTHER		
TOTALS		

F. LIFE INSURANCE

COMPANY NAME (include address and policy No.)	**TYPE**	**DEATH BENEFIT VALUE**	**FACE VALUE**	**CASH VALUE**	**INSURED**	**OWNER**	**BENEFICIARY**

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

G. GIFTS

Please list gifts made in excess of $100.00 in any one month, to an individual or group of individuals, within the past 60 months:

Recipient _____ Date_____ Amount_____

Recipient _____ Date_____ Amount_____

Recipient _____ Date_____ Amount_____

Recipient _____ Date_____ Amount_____

Have you ever filed a Federal Gift Tax Return? Yes No

Once completed, please return this form to:

AshBer
551 Windy Wood Lane
Wrightstown, WI 54180
Phone: 888.441.1595
Fax: 404.393.0747
amber@ashber.com