



CRISIS MEDICAID PLANNING QUESTIONNAIRE – MARRIED COUPLE

Attorney or
Advisor's Contact
Information

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

A. PERSONAL DATA

(Husband) (Wife)
Full Name _____ Full Name _____

Street
Address _____

City _____ State _____ Zip _____

(Husband) (Wife)
Birth Date _____ Birth Date _____

U. S. Citizen? Yes ☐ No ☐ U. S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐ Veteran? Yes ☐ No ☐

B. MEDICAL DATA

Name of Ill Spouse _____

Diagnosis _____

Course of Treatment _____

Where Ill Spouse Currently Resides _____

Name of Well Spouse _____

Health of Well Spouse _____

Where Well Spouse Currently Resides _____

If either spouse 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

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	\$ _____	\$ _____
Retirement Benefits (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
\$ _____	Monthly Incidental Cost
\$ _____	Monthly Prescription Cost
\$ _____	Monthly Other Cost
\$ _____	Total Monthly Costs

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

G. ASSETS/LIABILITIES

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

Asset	Husband	Wife	Joint	Liabilities
AUTOMOBILE				
ADDITIONAL AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
IRA				
OTHER REAL ESTATE				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

Total countable resources as of the first continuous period of institutionalization: \$ _____

H. 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.

I. 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 ☐

If so, please state details _____

Once completed, please return this form to:

AshBer
551 Windy Wood Lane
Wrightstown, WI 54180
Phone: 888.441.1595
Fax: 678.528.1290
amber@ashber.com