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MEDICAID PLANNING QUESTIONNAIRE
-MARRIED-

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Please bring this information with you to the appointment.

Date _____

A. PERSONAL DATA

(Husband)

(Wife)

Full Name _____
(print name as shown on your checks)

Full Name _____
(print name as shown on your checks)

Cell Phone No. _____

Cell Phone No. _____

Business Phone No. _____ Ext. _____

Business Phone No. _____ Ext. _____

E-mail Address _____

E-mail Address _____

Fax No. _____

Fax No. _____

Home Phone No. _____

Street Address _____

City _____ State _____ Zip _____

(Husband)

(Wife)

Birth Date _____

Birth Date _____

Social Security No. do not include unless asked

Social Security No. Do not include unless asked

U.S. Citizen? Yes No

U.S. Citizen? Yes No

Veteran? Yes No

Veteran?

Yes No

B. MEDICAL DATA

1. HEALTH

Name of Ill Spouse_____

Diagnosis_____

Prognosis_____ Course of Treatment _____

If Ill Spouse has already entered a nursing home, please indicate the name of the nursing home and the date first entered on a continuous basis_____

Name of Well Spouse_____

Where Well Spouse Currently Resides _____

Health of Well Spouse _____

If you are in an Assisted Living Facility, please indicate name of facility and date first entered.

Name of Assisted Living Facility _____

Address_____

Telephone No._____

Date Entered_____

2. PHYSICIAN

Full Name of Husband's Primary Physician_____

Street Address_____

City_____ State_____ Zip_____

Full Name of Wife's Primary Physician _____

Street Address_____

F. MONTHLY NON-SHELTER LIVING EXPENSES

Food \$ _____
Medical \$ _____
Clothing \$ _____
Transportation (including auto insurance) \$ _____
Home Maintenance \$ _____
Life Insurance Premiums \$ _____
Health Insurance Premiums \$ _____
Cable TV & Internet \$ _____
Federal and State Income Taxes \$ _____
Other \$ _____

Total Monthly Non-Shelter Living Expenses \$ _____

G. GIFTS

Have you made gifts in excess of \$5,000 in any one month, to an individual or group of individuals, within the past 60 months, or to a trust within the past 60 months? Yes No

If yes, list below:

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 _____

H. LIFE INSURANCE

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____
Insured _____ Beneficiary _____
Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____
Insured _____ Beneficiary _____
Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____
Insured _____ Beneficiary _____
Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

Name of Insurance Company _____ **Policy #** _____
Street Address _____
City _____ State _____ Zip _____
Type of Policy _____ Owner _____

Insured _____ Beneficiary _____

Death Benefit: \$ _____ Face Value: \$ _____ Cash Value: \$ _____

I. CHILDREN

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Cell Number _____

Date of Birth _____ Social Security Number – ONLY If Specifically Requested

Marital Status: Single _____ Married _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Cell Number _____

Date of Birth _____ Social Security Number ONLY If Specifically Requested

Marital Status: Single _____ Married _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Cell Number _____

Date of Birth _____ Social Security Number ONLY If Specifically Requested

Marital Status: Single _____ Married _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Cell Number _____

Date of Birth _____ Social Security Number ONLY If Specifically Requested

Marital Status: Single _____ Married _____

Name of Child _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail Address _____

Cell Number _____

Date of Birth _____ Social Security Number ONLY If Specifically Requested

Marital Status: Single _____ Married _____

Does the Husband have any children by a previous marriage? Yes No

Does the Wife have any children by a previous marriage? Yes No

Are all of your children in good health? Yes No

Are any of your children blind? Yes No

Are any of your children disabled? Yes No

Are any of your children receiving SSI or other form of government entitlement? Yes No

Do any of your family members have any problems with:

AIDS/HIV?	Yes	No
Drug Addiction?	Yes	No
Alcoholism?	Yes	No
Spendthrift?	Yes	No

Do any of your children live with you in your home? Yes No

If yes, name of child _____

J. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? Yes No

If yes, please explain _____

K. REFERRAL

By Whom Were You Referred To This Office?

Name _____

Street Address _____

City _____ State _____ Zip _____

ASSETS/LIABILITIES

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

ASSETS	HUSBAND	WIFE	JOINT	LIABILITIES
PERSONAL EFFECTS				
AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ (Obtain from Tax Bill)				
OTHER REAL ESTATE				
ADDITIONAL AUTOMOBILES				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
CASH VALUE - LIFE INSURANCE				
IRA				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

What did you pay for your current home including any improvements? \$ _____

Address of any real property other than personal residence:

(1) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____

(2) Street _____ City _____ State _____ Zip _____

Tax Block # _____, Lot # _____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? \$ _____

Name of Homeowner's Insurance Company _____

Street Address _____

City _____ State _____ Zip _____

Phone No. _____ Policy No. _____

L. CERTIFICATION

The undersigned hereby represents to Law Office of Catherine T. Calabria, and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative: Dated:

Signature of Client or Client Representative: Dated:
