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MEDICAID PLANNING QUESTIONNAIRE
-SINGLE-

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

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

Home Phone No. _____ Business Phone No. _____
Extension: _____

Cell Phone No. _____ E-mail Address _____ Fax
No. _____

Street Address _____

City _____ State _____ Zip Code

Birth Date _____ Social Security No. -WE WILL REQUEST IF NEEDED

U.S. Citizen? Yes No Veteran? Yes No

If widowed, please list date of death of spouse _____

Was your former spouse a Veteran? Yes No

B. MEDICAL DATA

1. HEALTH

Diagnosis _____

Prognosis _____

Course of Treatment _____

If you are already in a nursing home, please indicate the name of the nursing home and the date first entered

Name of Nursing Home _____

Address _____

Telephone No. _____ Date Entered Facility

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

Name of Assisted Living Facility _____

Address _____

Telephone Number _____ Date Entered Facility

2. PHYSICIAN

Full Name of Primary Physician _____

| | |
|-----------------------------|-----------------|
| Retirement Benefits (Gross) | \$ _____ |
| Veterans Disability Income | \$ _____ |
| Annuity Income | \$ _____ |
| Rental Income | \$ _____ |
| TOTAL MONTHLY INCOME | \$ _____ |

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.

Could this pension amount increase in the future? Yes No

Do not include interest and dividend income on this form.

D. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12 and quarterly expenses by 3)

| | |
|--|-----------------|
| Rent/Mortgage | \$ _____ |
| Real Estate Taxes | \$ _____ |
| Water | \$ _____ |
| Sewer | \$ _____ |
| Utilities (Heat, Electric & Telephone) (1/12th of last 12 months) | \$ _____ |
| Homeowner's insurance premium | \$ _____ |
| Condominium fees | \$ _____ |
| Total Monthly Housing Expenses | \$ _____ |

E. MONTHLY NON-SHELTER LIVING EXPENSES

Food \$ _____

Medical \$ _____

Clothing \$ _____

Transportation (including auto insurance) \$ _____

Home Maintenance \$ _____

Life Insurance Premiums \$ _____

Health Insurance Premiums \$ _____

Cable TV & Internet \$ _____

F. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost \$ _____

Monthly Prescription Cost \$ _____

Monthly Incontinent Cost \$ _____

Monthly Other Cost \$ _____

Total Monthly Cost \$ _____

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

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 36 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 _____

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 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 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 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 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 requested

Marital Status: Single _____ Married _____

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 _____

Does a sibling live in your home with you? Yes No

If yes, name of sibling _____

ASSETS/LIABILITIES

Please insert the value and owner of each asset in the appropriate space.

| ASSET/LIABILITY | ASSET TOTAL | NAME ON ACCOUNT |
|--|-------------|-----------------|
| PERSONAL EFFECTS | | |
| CHECKING ACCOUNT -BANK NAME: _____ | | |
| SAVINGS ACCOUNT - BANK NAME: _____ | | |
| MONEY MARKET ACCOUNT - BANK NAME: _____ | | |
| CERTIFICATES OF DEPOSIT - BANK NAME: _____ | | |
| RESIDENCE (ASSESSED VALUE) BLOCK# _____ LOT# _____ (Obtain from Tax Bill) | | |
| OTHER REAL ESTATE | | |
| AUTOMOBILE(S) | | |
| MUTUAL FUNDS | | |

| | | |
|--------------------------------|--|--|
| STOCKS | | |
| BONDS (Series E, EE, HH, etc.) | | |
| ANNUITIES | | |
| CASH VALUE - LIFE INSURANCE | | |
| IRA | | |
| NURSING HOME DEPOSIT | | |
| OTHER | | |
| OTHER | | |
| TOTAL | | |

Please list any liabilities. _____

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. _____

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 _____

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:
