



MEDICAID PLANNING

The extreme costs of nursing home and other elder care expenses could deplete a family's assets very quickly. Medicaid planning with Sawyer & Sawyer, PA can help protect an individual's assets while still qualifying them for Medicaid benefits.

The proper planning could also include estate planning and protecting assets for the Medicaid applicant's spouse.

Our full Medicaid Planning process has several stages:

1. Meeting with the client to discuss their situation and the Medicaid rules.
2. Reviewing a completed Medicaid Planning intake form with the best possible information provided by the client.
3. Gather financial documentation so our attorney can properly analyze the client's information in detail.
4. Develop a plan to protect assets and qualify for Medicaid.
5. Assisting the client in implementing the eligibility plan.
6. Applying for Medicaid and providing the supporting eligibility documentation to the Florida Department of Children and Families.

Please review and complete the attached intake form with as much detail as possible. Return it to us prior to your appointment or bring it with you.

We look forward to helping your family.



Benefits Planning Questionnaire

This questionnaire is designed to help us gather the information needed to create a plan to protect your assets (or the assets of your family member or friend). This questionnaire is essential to our understanding of your case. Please complete it with as much detail possible.

Feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

>>Information is needed for each spouse in every instance, unless otherwise specified.

Date: _____ How were you referred to us? _____

YOUR GOALS

What are your goals for meeting with us?

Two horizontal lines for writing goals.

SECTION 1. NAME AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____
Address City, State, Zip Code

(email) (phone number-main)

Your Relationship to Client _____
(Client is the Medicaid Applicant)

Client's Full Name: _____
(first) (middle) (last)

Client's Spouse Full Name: _____
(first) (middle) (last)

Home Address: _____
Address City, State, Zip Code

Client's Marital Status: () Married () Single () Divorced () Widowed () Co-habiting

Client

Spouse

Telephone Numbers: _____
(home) (home)

(cell) (cell)

Email Address: _____

Date of Birth: _____

Former/Maiden Name: _____

US Citizen? [] Yes [] No [] Yes [] No

Social Security Number: _____

Military Service Dates: _____

Date of Death: _____ (If widowed)

Date of Marriage: _____

Prior Marriages: _____

SECTION 2. FACILITY

A. Client

Currently in a Facility? [] Yes [] No

If so, date entered: _____

Name of Facility/Provider: _____

Facility Address: _____
Address City, State, Zip Code

Administrator or Contact: _____

(email) (phone number)

B. Spouse

Currently in a Facility? [] Yes [] No

If so, date entered: _____

Name of Facility/Provider: _____

Home Address: _____
Address City, State, Zip Code

Administrator or Contact: _____

(email) (phone number)

SECTION 3. CHILDREN

List **ALL** children belonging to each spouse. Copy and attach additional pages, if needed.

Client: Total number of children: _____ **Spouse:** Total number of children: _____

Do all the children and/or step-children have a good relationship? [] Yes [] No

If no, please explain: _____

Do any of the children and/or step-children have any objections to Medicaid Planning or a spend down of assets? [] Yes [] No

If yes, please explain: _____

1. _____ (name of child) _____ (spouse's name)

Parent: [] Client [] Spouse [] Both

Disabled? [] Yes [] No

_____ (current full address) _____ (phone number-main)

_____ (email address) _____ (phone number-other)

2. _____ (name of child) _____ (spouse's name)

Parent: [] Client [] Spouse [] Both

Disabled? [] Yes [] No

_____ (current full address) _____ (phone number-main)

_____ (email address) _____ (phone number-other)

3. _____ (name of child) _____ (spouse's name)

Parent: [] Client [] Spouse [] Both

Disabled? [] Yes [] No

_____ (current full address) _____ (phone number-main)

_____ (email address) _____ (phone number-other)

4. _____ (name of child) _____ (spouse's name)
 Parent: Client Spouse Both
 Disabled? Yes No

 (current full address) _____ (phone number-main)

 (email address) _____ (phone number-other)

5. _____ (name of child) _____ (spouse's name)
 Parent: Client Spouse Both
 Disabled? Yes No

 (current full address) _____ (phone number-main)

 (email address) _____ (phone number-other)

SECTION 6. ESTATE PLANNING AND OTHER DOCUMENTS

Please provide a copy of each document.

	<u>Client</u>	<u>Spouse</u>
Will:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Revocable Living Trust:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Durable Power of Attorney:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Care Surrogate:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living Will:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 7. TRANSFERS TO OR FROM TRUSTS

Has the person needing care (or his or her spouse) transferred property into a Trust or out of a Trust (revocable or irrevocable) within the past 60 months? If so, please provide the following information:

A. Client

<u>Name of Trust</u>	<u>Amount/Value of Transfer</u>	<u>Date of Transfer</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____

SECTION 8. INCOME

A. GROSS MONTHLY INCOME (List **gross** income amounts before deductions)

	<u>Client</u>	<u>Spouse</u>
1. Social Security:	\$ _____	\$ _____
2. _____ :	\$ _____	\$ _____
3. _____ :	\$ _____	\$ _____
4. _____ :	\$ _____	\$ _____
5. _____ :	\$ _____	\$ _____

[Use other side if necessary]

SECTION 9. HEALTH INSURANCE (For each spouse)

Client Spouse

Medicare Number: _____

If the person needing care has private health, or is paying for a Medicare supplement policy, please provide the following information:

<u>Name of Insurer</u>	<u>Policy No.</u>	<u>Type of Policy</u>	<u>Monthly Prem.</u>
Acme Insurance (sample)	123-45-6789	Supplemental	\$ 250.00
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

SECTION 10. LONG-TERM CARE INSURANCE (For each spouse)

If the person needing care has private health, or is paying for a Medicare supplement policy, please provide the following information:

<u>Name of Insurer</u>	<u>Policy No.</u>	<u>Type of Policy</u>	<u>Monthly Prem.</u>	<u>If LTC, Daily Benefit</u>
Acme Insurance (sample)	123-45-6789	Long-term care	\$ 500.00	\$ 100.00 per day
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

How does the policy pay? Check one: Reimbursement () Direct to the facility ()



SECTION 11. ASSETS AND RESOURCES

(All accounts jointly or individually owned by each spouse, including those with third-party co-owners)

A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)

<u>Name of Bank</u>	<u>Account No.</u>	<u>Type of Account</u>	<u>Balance/Value</u>	<u>How Title Held</u>
Big Bank/Main St. (sample)	xxx-xxxx	Savings	\$ xx,xxx.xx	Jointly w/ son
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____
_____	_____	_____	\$ _____	_____

B. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.) (For both spouses)

<u>Name of Institution</u>	<u>Account No.</u>	<u>Owner</u>	<u>Beneficiary</u>	<u>Date Est.</u>	<u>Current Value</u>
Big Broker (sample)	xxx-xxxx	Client	Spouse	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

C. ANNUITIES (For both spouses)

<u>Name of Institution</u>	<u>Account No.</u>	<u>Owner</u>	<u>Beneficiary</u>	<u>Date Est.</u>	<u>Current Value</u>
Company Name (sample)	xxx-xxxx	Client	Spouse	Jan, 1970	\$ xx,xxx.xx
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	_____	\$ _____

SECTION 12. LIFE INSURANCE (For each spouse)

<u>Name of Insurer</u>	<u>Policy No.</u>	<u>Owner</u>	<u>Monthly Prem.</u>	<u>Cash Surrender Value</u>
Acme Insurance (sample)	123-45-6789	Client	\$ 50.00	\$ 10,000
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

SECTION 13. RESIDENCE (Homestead) – OWNED [If rent, go to section 8]

- A. Address: _____
- B. Names on the deed: _____
- C. Fair Market Value: \$ _____
- D. Mortgage Balance: \$ _____
- E. Is it a Reverse Mortgage? Yes No
- F. Is there lot rent? Yes No If yes, how much? _____

SECTION 14. RESIDENCE – RENTED

- A. Monthly Rent: \$ _____
- B. Rental/Lease Agreement? Yes No

SECTION 15. MONTHLY COST OF LIVING

- A. **HOUSING (ESTIMATED PER MONTH)**
 - Mortgage \$ _____
 - Property Taxes \$ _____
 - Property Insurance \$ _____
 - Homeowner’s Association Fees \$ _____
 - If home is rented, total rent: \$ _____

SECTION 16. ADDITIONAL REAL PROPERTY #1

(All property jointly or individually owned by each spouse, including those with third-party co-owners)
(Use back of page, if needed)

- A. Address: _____
- B. Names on the deed: _____
- C. Fair Market Value: \$ _____
- D. Mortgage Balance: \$ _____
- E. Currently being rented? [] Yes [] No If rented, monthly rent is: _____

ADDITIONAL REAL PROPERTY #2

(All property jointly or individually owned by each spouse, including those with third-party co-owners)
(Use back of page, if needed)

- A. Address: _____
- B. Names on the deed: _____
- C. Fair Market Value: \$ _____
- D. Mortgage Balance: \$ _____
- E. Currently being rented? [] Yes [] No If rented, monthly rent is: _____

SECTION 17. VEHICLES

List all vehicles owned by the client or spouse, including cars, trucks, motorcycles, recreational vehicles, boats, campers.

<u>Type of Vehicle</u>	<u>Owner Name(s)</u>	<u>Make and Model</u>	<u>Year</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 18. BURIAL/FUNERAL ARRANGEMENTS

Under the Medicaid rules, certain items are “exempt” from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

	<u>Client</u>	<u>Spouse</u>
Burial plot:	[] Yes [] No	[] Yes [] No
Irrevocable burial fund contract:	[] Yes [] No	[] Yes [] No

SECTION 19. TRANSFERS OF ASSETS WITHIN THE LAST 60 MONTHS

Has the client or spouse transferred any assets or property to someone within the past 60 months? If so, please describe below. Transfers include any financial assistance to anyone, including loans, paying someone’s bills and/or living expenses, plus gifts of cash or assets. Use the back of this page if additional room is needed.

<u>Recipient</u>	<u>Amount/Value of Gift</u>	<u>Date of Gift</u>
1. _____	\$ _____	_____
2. _____	\$ _____	_____
3. _____	\$ _____	_____
4. _____	\$ _____	_____
5. _____	\$ _____	_____

SECTION 20. CLOSED ACCOUNTS OR SOLD ASSETS WITHIN THE LAST 60 MONTHS

Has the client or spouse closed an account or sold an asset within the past 60 months? If so, please describe below. Use the back of this page if additional room is needed.

<u>Account or Asset</u>	<u>Account No.</u>	<u>Type of Account</u>	<u>Closing Value</u>	<u>Where Deposited?</u>
Bank Name _____ <small>(sample)</small>	123-45-6789	Checking	\$ 500.00	\$ Other Bank #12345
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____
_____	_____	_____	\$ _____	\$ _____

SECTION 21. DEBT (Enter the outstanding balance of debt of each spouse)

<u>Description/Type of Debt</u>	<u>Whose debt?</u>	<u>Creditor</u>	<u>Balance</u>
Credit card (sample)	John and Jane's	US Bank	\$ xx,xxx.xx
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

SECTION 22. OTHER INFORMATION

A. PERSONAL PROPERTY OF HIGH VALUE (For each spouse)

	<u>Market Value / Date Transferred</u>	<u>Description</u>
Jewels, Furs, Art, etc.:	\$ _____	_____
_____:	\$ _____	_____
(other: collectibles, etc.)	\$ _____	_____
_____:	\$ _____	_____

B. BUSINESS INTERESTS (For each spouse)

If the person needing long-term care has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners.

C. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

(For each spouse)

Briefly describe or give the name of the Trust in which the person (client or spouse) has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available.

D. SAFE DEPOSIT BOX

If the client or spouse has a safe deposit box, please describe the contents:

PLEASE SIGN BELOW AND BRING THIS COMPLETED QUESTIONNAIRE WITH YOU TO YOUR APPOINTMENT.

I understand that it is my responsibility to disclose correct and complete information concerning the applicant's and the spouse's financial assets, income, and personal circumstances that relate to eligibility for Medicaid or VA benefits. I hereby attest that the information I have supplied is complete and accurate to the best of my knowledge.

I realize that any changes in the applicant's circumstances that might affect Medicaid or VA benefit eligibility must be reported as soon as possible. I will disclose new or previously undiscovered assets, as it becomes known to me. I acknowledge that any undisclosed or later discovered income or assets may result in delayed planning, additional planning costs or Medicaid benefits denial.

Sign: _____ Date: _____

Print Name: _____

Please note that written documentation is not required for initial consultations. However, the documentation listed below is what our firm will require from you should you engage us in Medicaid or other benefits planning. Extensive documentation will be essential for a successful plan, so please plan accordingly.

BENEFITS PLANNING DOCUMENTATION

1. OPEN accounts:

- The last twelve (12) months of statements for all open financial accounts, i.e. checking, savings, money markets, investment accounts, mutual funds, etc.

NOTE: Always provide every numbered page for any statement. More may be required.

2. CLOSED accounts:

- Final closing statement with zero balance;
- Statement prior to account closing;
- Statement from deposit account showing deposit of closed account proceeds.

NOTE: Always provide every numbered page for any statement.

3. Annuities:

- Copy of the original annuity contract;
- Statement showing the current value at the present time;
- The last twelve (12) months of statements;
- The year-end statement from the previous year.

NOTE: Always provide every numbered page for any statement.

4. IRAs:

- IRA statement from December 31st of the **previous year** showing the end of year value;
- Statement showing the current value now;
- The last twelve (12) months of statements;
- We may need a complete copy of the original IRA document.

NOTE: Always provide every numbered page for any statement.

5. CDs:

- Statement of current value;
- Last issued statement;
- Maturation date.

6. Stocks:

- Certificates; Current year dated documentation showing ownership and number of shares;
- Most recent dividend statements.

7. Bonds/T-Bills:

- Copies of the original documents, bonds, etc.;
- Most recent dividend/income statement;
- Current year documentation showing ownership and current value.

8. Savings Bonds:

- Copies of all bonds.

9. Life Insurance Policies:

- Current year dated statement direct from the company showing:
 1. Name of owner;
 2. Name of the insured;
 3. Beneficiary name;
 4. Face value, cash value and death benefit.

10. Income:

- Current year dated documentation direct from each income source for applicant or spouse. Documentation must show current monthly gross income and deductions.

NOTE: Bank statements and IRS 1099 forms are not acceptable income documentation per DCF rules.

11. Long-Term Care Policies:

- Complete copy of any long-term care policies for applicant and/or spouse and current year payment statements, if any.

12. Medicare Supplemental or Health Insurance Policies:

- Current year dated policy premium statements for both applicant and spouse showing the current premium amounts.

13. Funeral/Burial/Cremation Contracts:

- Complete, good quality copies of all funeral/burial/cremation contracts for applicant and spouse;
- Irrevocable statements for each contract, if any;
- Cemetery plot deeds and ownership documentation.

14. Homestead:

- Copy of deed/title to homestead/residence;
- Current year tax statement;
- Current homeowner's insurance policy premium declaration page;
- Current statement of association fees, if any;
- Mortgage statement showing monthly payment and balance owed.

15. Other Real Property:

- Copy of deed/title to properties;
- Current year tax statement;
- If rented, copy of lease/rental agreement;
- Current property insurance policy premium declaration page;
- Current statement of association fees, if any;
- Mortgage statement showing monthly payment and balance owed for homestead.

16. Mortgages/Loans/Promissory Notes Made by Applicant or Spouse:

- Documentation of any mortgage, loan, and/or promissory note owed to applicant or spouse;
- Record of any payments made.

17. Identification (Both applicant and spouse) Copy front & back of each card:

- Social Security Card;
- Medicare Card;
- Medicare Supplemental or Health Insurance Card;
- Driver's License or Photo ID;
- Resident Alien Registration Card/Naturalization Paper;
- Birth Certificate or Passport;
- Marriage License;
- Military discharge papers or DD214.

18. Vehicles:

- Copy of registrations or title(s) issued for cars, mobile homes, boats, trailers, trucks, vans, recreational vehicles, or other vehicles registered to applicant/spouse.

19. Estate Planning Documents:

- Copies of current Will, Trust, Power of Attorney, and other Estate Planning Documents for applicant and spouse.