Fitzwater Meyer Hollis & Marmion, LLP

PUBLIC BENEFITS PLANNING SHEET

Please fill in following form as completely as possible. If a blank or section does not apply, please indicate by crossing it out or indicating not applicable (N/A)

Date_____

Your Name(s) _____

Address _____

Billing Address (if different from above)_____

City _____ State _____ Zip_____

Phone _____

Birth date(s) _____ Marital Status _____

Social Security No.(optional)_____

E-mail(s) _____

Would you like to receive our email newsletters?

Elderlaw Newsletter ☐ **Yes** ☐ **No**
Special Needs Newsletter ☐ **Yes** ☐ **No**

Referred by:

- ☐ Attorney Name_____
- ☐ Accountant Name_____
- ☐ Financial Planner Name _____
- ☐ Senior Program Name of Program _____
- ☐ Medical Provider Name _____
- ☐ Senior Center Name of Center _____
- ☐ Friend/Family Name _____
  - ☐ Website ☐ Brochure ☐ Newspaper ☐ Radio/TV
  - ☐ Yellow Pages ☐ Metro Parent magazine
- ☐ Other Please explain _____

BACKGROUND INFORMATION ABOUT APPLICANT AND SPOUSE

Medicaid applicant: _____
(First) (Middle) (Last)

Applicant's Date of Birth: _____

Applicant's Social Security Number:_____

Applicant's Spouse/Partner (if any): _____

Applicant's Spouse/Partner Date of Birth:_____

Applicant's Spouse/Partner Social Security Number: _____

Applicant currently lives: ☐ at Home ☐ in a Facility

Name of Facility: _____

Type of Facility: ☐ Foster Home ☐ Assisted Living ☐ Nursing Home
☐ Memory Care ☐ Don't know

Address: _____

City: _____ State:_____Zip: _____

Phone Number: _____ County:_____

FAMILY INFORMATION

Name of child(ren):	Date of Birth:
_____	_____
_____	_____
_____	_____

Does the Medicaid applicant have any of the following:

Will: ☐YES ☐NO Copy Provided: ☐YES ☐NO

Trust: ☐YES ☐NO Copy Provided: ☐YES ☐NO

Power of Attorney: ☐YES ☐NO Copy Provided: ☐YES ☐NO

INCOME INFORMATION

For Income Information: our office needs documents to prove the amounts of gross income provided below (e.g. Social Security Award Letters; Pension Stubs; Check Stubs, etc.).

APPLICANT'S INCOME INFORMATION				
SOURCE	GROSS AMOUNT	LIST DEDUCTIONS AND AMOUNTS	NET AMOUNT	DOCUMENT PROVIDED
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO

APPLICANT'S SPOUSE OR PARTNER'S INCOME INFORMATION				
SOURCE	GROSS AMOUNT	LIST DEDUCTIONS	NET AMOUNT	DOCUMENT PROVIDED
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO

HEALTHCARE INFORMATION

APPLICANT HEALTH INSURANCE INFORMATION				
PROVIDER *(Medicare / Blue Cross / Kaiser)*	MONTHLY PREMIUM	HOW PAID *(auto withdrawal / withholding / check / other)*	SOURCE OF PAYMENT	DOCUMENT PROVIDED
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO

SPOUSE / PARTNER HEALTH INSURANCE INFORMATION				
PROVIDER *(Medicare / Blue Cross / Kaiser)*	MONTHLY PREMIUM	HOW PAID *(auto withdrawal / withholding / check / other)*	SOURCE OF PAYMENT	DOCUMENT PROVIDED
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO
				☐YES ☐NO

ASSET AND PROPERTY INFORMATION

Please list all assets and resources owned by the Medicaid applicant and/or the applicant's spouse. Indicate who owns which asset, or if jointly owned.

REAL PROPERTY INFORMATION					
ADDRESS	TAX APPRAISED VALUE	PROPERTY TAXES PER YEAR	HOME INSURANCE PER YEAR	OWNER	MORTGAGE PAYMENT PER MONTH

BANK ACCOUNT INFORMATION					
NAME OF INSTITUTION *(name of bank)*	TYPE OF ACCOUNT *(checking savings / cd)*	ACCOUNT NUMBER *(last 4 digits)*	STATEMENT DATE *(mm/dd/yyyy)*	ACCOUNT VALUE	OWNER

LIFE INSURANCE POLICIES					
NAME OF INSTITUTION	TYPE OF POLICY	BENEFICIARY	STATEMENT DATE	CASH VALUE	POLICY OWNER

OTHER INVESTMENTS (IRA, Stocks, Mutual Funds)					
NAME OF INSTITUTION	TYPE OF ACCOUNT	ACCOUNT NUMBER	STATEMENT DATE	ACCOUNT VALUE	OWNER

Other Assets Not Listed Above:

_____
_____
_____
_____
_____
_____
_____

INFORMATION ABOUT CERTAIN MONTHLY EXPENSES

Monthly Rent or Mortgage payments (if any): $_____

Property Taxes: $_____/year or $_____/ month

Homeowners or Renter's Insurance: $_____/ month

Condo or Maintenance Fees (if any): $_____/ month

Which utilities does the applicant or spouse pay:
☐Water ☐Gas
☐Heat ☐Sewer
☐Electricity ☐Trash

STATUS OF MEDICAID APPLICATION

Have you applied for Medicaid yet: ☐YES ☐NO

What was the date you requested an application: _____

Date that the applicant began paying for care (either in home or in a facility): _____

Name of Current Medicaid Caseworker: _____

Telephone Number of Caseworker: _____

Date by which you want Medicaid to start paying for care: _____