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The following is a list of materials needed in your first Medicaid planning appointment.

1. Current Power of Attorney documents for each of you;
2. Your most current wills and trust agreements;
3. Deed(s) to any real estate you own;
4. The current value of any checking and/or savings accounts you own;
5. The current value of any stock and/or bonds you own;
6. Any insurance policies you own (including annuities); and
7. The current monthly income each of you receives.

**Client Information Sheet
Married Couple**

Please complete this form prior to your initial meeting to allow us to more efficiently serve your needs. This form is intended to be completed by married couples. For convenience, when completing this form, the husband is the "Client" and the wife is the "Spouse". Otherwise, the sole person completing the form is the "Client". Please use the back of the form if additional space is needed.

Personal Information:

A. Client's Name: _____
First Middle Initial Last

Age: _____ Date of Birth: _____

Last grade completed: _____

Have you ever been convicted of a felony? Yes _____ No _____

U. S. Citizen: Yes _____ No _____

Have you or your spouse served in the military on active duty during a wartime period?
Yes _____ No _____

Social Security No.: _____ County of domicile: _____

Street (Road) address: _____

Post Office Box (if applicable): _____

City, State & Zip: _____

Telephone No.: Home: _____ Work: _____

E-mail Address: _____

Has anyone lived with you and your spouse or have you or spouse lived with anyone during the last two years? Yes _____ No _____

If yes, please explain the circumstances: _____

B. Spouse's Name: _____
First Middle Initial Last

Age: _____ Date of Birth: _____

Last grade completed: _____

Have you ever been convicted of a felony? Yes _____ No _____

U. S. Citizen: Yes _____ No _____

Social Security No.: _____

Telephone No.: _____ Work: _____

E-Mail Address: _____

C. Contact Person/POA: _____
First Middle Initial Last

Street (Road) address: _____

Post Office Box (if applicable): _____

City, State & Zip: _____

Telephone No.: Home: _____ Work: _____

E-Mail Address: _____

D. Names and addresses of each of your children:

Name (first, middle initial, last):	Address/Phone:
1. _____	_____ _____
2. _____	_____ _____
3. _____	_____ _____

(next page for additional children)

- 4. _____
- 5. _____
- 6. _____

Do any of your children receive Social Security Disability benefits? _____

E. During any time after September 30, 1989, have you or your spouse ever been in a hospital and/or nursing home for more than 30 consecutive days? Yes _____ No _____

Loans:

Does anyone presently owe you any money (or other debt)? Yes _____ No _____

If yes, do you have written documentation signed by the debtor? Yes _____ No _____

Please list the amount owed to you for each loan and payment terms: _____

Monthly Income:

	<u>Client</u>	<u>Spouse</u>
Social Security	_____	_____
Pension	_____	_____
Annuity	_____	_____
Other	_____	_____
Total	_____	_____

Expenses:

Supplemental Health Insurance (please list separately for Client and Spouse):

Client's Monthly premium: _____ Company Name: _____

Spouse's Monthly premium: _____ Company Name: _____

Do you or your spouse have Medicare Part C coverage? _____

Medicare Part D (Prescription) Coverage:

Client's Monthly premium: _____ Company Name: _____

Spouse's Monthly premium: _____ Company Name: _____

Monthly Utilities: _____

Monthly House payment or rent payment: _____

Annual Real Estate Taxes: _____

Annual Property Insurance: _____

Assets:

Do you own a qualified annuity (funded with retirement funds)? Yes _____ No _____

Do you own a non-qualified annuity (not funded with retirement funds)? Yes _____ No _____

Real Estate:

Address: _____

Acreage: _____

Please provide a copy of the most current deed(s) and real estate tax bill(s).

Vehicle(s): _____

Bank Accounts (please add additional pages as necessary):

Name of Bank: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Name of Bank: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Other Investments:

Name of Company: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Name of Company: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Type of Account/Account Number: _____

Current Balance: _____

Life Insurance (please add additional pages as necessary):

Company: _____

Policy Number: _____ Value: _____

Company: _____

Policy Number: _____ Value: _____

Nursing Home Insurance:

Company: _____

Policy Number: _____ Elimination Period: _____

Daily or Monthly Benefit: _____

Benefit Length: _____

Other Assets: _____

Do you own cemetery lots? Yes _____ No _____

If yes, please provide a copy of the deed for such lot(s).

Do you own prepaid funeral arrangements? Yes _____ No _____

If yes, please provide us with all documents pertaining to such arrangements.

Gifts:

Please list the date, amount and the person receiving any gift of over \$3,000 in any one month either of you have made in the last five years for gifts made prior to November 1, 2009.

<u>Date</u>	<u>Amount</u>	<u>Recipient</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For gifts made on or after November 1, 2009, please list all gifts made (no matter how small or for what reason—including gifts to charities and churches). Please use a separate sheet of paper if necessary.

<u>Date</u>	<u>Amount</u>	<u>Recipient</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral:

Who referred you to this office?:

Name: _____

Street Address _____

City _____ State _____ ZIP _____

Client's Signature

Spouse's Signature

Date:

Date:
