

MEDICAID QUESTIONNAIRE

NOTICE OF CONFIDENTIALITY

THE INFORMATION IN THIS DOCUMENT IS SUBJECT TO THE ATTORNEY-CLIENT PRIVILEGE, AS PROVIDED IN THE TEXAS RULES OF EVIDENCE.

THE CONTENTS OF THIS DOCUMENT CONSTITUTE ATTORNEY WORK PRODUCT.

THE CONTENTS OF THIS DOCUMENT ARE CONFIDENTIAL AND ARE NOT TO BE DISCLOSED TO THIRD PERSONS OTHER THAN THOSE TO WHOM DISCLOSURE IS MADE IN FURTHERANCE OF THE RENDITION OF PROFESSIONAL LEGAL SERVICES.

Name: _____
Last First Middle Maiden

Date of Birth: _____ Sex: _____ Social Security No. _____ - _____ - _____

Place of Birth: _____

Living Arrangement:

___ own home ___ apartment/rent house ___ household of another
___ nursing home (entered _____) ___ assisted living/personal care home (entered _____)

Home Address – Street: _____

City: _____ State: _____ Zip code: _____

County: _____ Telephone No. (_____) _____

Mailing Address (if different): _____

City: _____ State: _____ Zip code: _____

Name of Spouse: _____

Last First Middle Maiden

Date of Birth: _____ Sex: _____ Social Security No. _____ - _____ - _____

Place of Birth: _____

Date of Death, if deceased: _____

Spouse's Living Arrangement:

___ own home ___ apartment/rent house ___ household of another
___ nursing home (entered _____) ___ assisted living/personal care home (entered _____)

Spouse's Home Address: _____

City: _____ State: _____ Zip code: _____

Do you have a legal guardian or Power of Attorney? Yes _____ No _____

Does your spouse have a legal guardian or Power of Attorney? Yes _____ No _____

Name of your Power of Attorney _____ Guardian _____

Your Power of Attorney's/Guardian's Address:

Your Power of Attorney's/Guardian's Telephone Number: (_____) _____

Name of spouse's Power of Attorney _____ Guardian _____

Spouse's Power of Attorney's/Guardian's Address:

Spouse's Power of Attorney's/Guardian's Telephone Number: (_____) _____

If no Power of Attorney or Guardian, Person Assisting with Financial and/or Personal Matters:

Address: _____

Telephone Number: (_____) _____

Do you have a Will? Yes _____ No _____

Does your spouse have a Will? Yes _____ No _____

Do you have a Medical Power of Attorney? Yes _____ No _____

Does your spouse have a Medical Power of Attorney? Yes _____ No _____

Do you have a Directive to Physicians: Yes _____ No _____

Does your spouse have a Directive to Physicians: Yes _____ No _____

Do you have a Declaration of Guardianship? Yes _____ No _____

Does your spouse have a Declaration of Guardianship? Yes _____ No _____

Do you have Medicare Part A? Yes _____ No _____

Do you have Medicare Part B? Yes _____ No _____

Does your spouse have Medicare Part A? Yes _____ No _____

Does your spouse have Medicare Part B? Yes _____ No _____

Health Insurance:	Company	Monthly Premium
Your Medicare Supplement:	_____	\$ _____
Spouse's Medicare Supplement:	_____	\$ _____
Your Prescription Plan:	_____	\$ _____
Spouse's Prescription Plan:	_____	\$ _____
Other:	_____	\$ _____
Other:	_____	\$ _____

Medical Condition:

Your Diagnosis: _____

Spouse's Diagnosis: _____

Resources: You and Your Spouse

Checking Accounts:	Account No.	Name of Institution	Amount

Savings Accounts:	Account No.	Name of Institution	Amount

Certificates of Deposit:	Account No.	Name of Institution	Amount

Money Market Certificates:	Account No.	Name of Institution	Amount

IRAs:	Account No.	Name of Institution	Amount

Retirement Accounts: (401(k), 403(b), etc.)	Account No.	Name of Institution	Amount

Investment Accounts, Annuities:	Account No.	Name of Institution	Amount

Savings Bonds: No. of Bonds Series Denomination Total Value

Certificated Stocks: No. of Shares Name of Company Total Value

Closed Accounts in Last 60 Months: Date Name of Institution Closing Balance

Authorized Signer on Other Accounts: Owner of Funds Name of Institution Amount

Safe Deposit Box Location: Yes _____ No _____

Contents: _____

Patient Trust Fund at Nursing Facility: Yes _____ No _____

Amount: _____

Cash on Hand: Amount: _____

Life Insurance: Policy Number Name of Company Face Value Cash Value

Burial Spaces: Name of Cemetery Number of Spaces Value

Preneed Funeral Contract: Name of Funeral Home Purchaser/Owner Value

Does Someone Pay You a Promissory/Mortgage Note: Date Name of Borrower Monthly Payment Balance

Trusts, Partnerships, Businesses, Other Entities: Date Name of Entity

Automobiles, Trucks, Boats, Recreational Vehicles:	Year	Make	Model	Value
	_____	_____	_____	_____
	_____	_____	_____	_____

Homestead, including Mobile Home:	Address	Amount of Land	Value
	_____	_____	_____

Other Land, Lots, Houses (total or part ownership):	Address	Amount of Land	Value
	_____	_____	_____
	_____	_____	_____

Oil, Gas, Mineral, Surface Rights:	Description	Producing or Non-Producing	Value
	_____	_____	_____
	_____	_____	_____

Livestock, Poultry:	Description	Value
	_____	_____
	_____	_____

Work Equipment:	Description	Value
	_____	_____
	_____	_____

Ownership Interest in Anything Not Listed Above:	Description	Value
	_____	_____
	_____	_____

Have you transferred, deeded, sold, loaned, or given away any houses, lots, land, money, or anything else in the past 60 months? Yes _____ No _____

If Yes:	Date of Transaction	To Whom?	Market Value	Value Received
Item	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Income: You and Your Spouse

Social Security: Self:	Claim No.	Gross Monthly Amount
Spouse:	_____	_____
	_____	_____

Veterans Administration: Self:	Claim No.	Gross Monthly Amount
Spouse:	_____	_____
	_____	_____

Other Retirement:	Description	Gross Monthly Amount
Self:	_____	_____
Self:	_____	_____
Spouse:	_____	_____
Spouse:	_____	_____

Earnings:	Description	Gross Monthly Amount
Self:	_____	_____
Spouse:	_____	_____

Rental Income:	Description	Gross Monthly Amount
Self:	_____	_____
Spouse:	_____	_____

Oil, Gas, Mineral Royalties:	Description	Gross Monthly Amount
Self:	_____	_____
Spouse:	_____	_____

Did anyone refer you? Yes _____ No _____ If yes, whom: _____