Medicaid Planning Information Form

5600 Harrison Avenue
Cincinnati, Ohio 45248
513.251.4900
www.niehaus-law.com

Please complete the form to the best of your ability. This information will be used to assess Medicaid planning options for your family. It will be kept confidential.

Contact Person: ______________________________

Relationship to potential Medicaid applicant: ______________ DOB: ______________

Address: ______________________________

Phone: (H) ____________ (W) ____________ (Cell) ______________

Information regarding the potential Medicaid applicant:

Name: ______________________________

Date of Birth: ______________ Social Security #: ______________

Residence address: ______________________________

☐ Home / Independent ☐ Assisted Living ☐ Full Nursing Care ☐ Other: __________

If applicable, Name of Facility: ______________ Date of Admission: ____________

Marital Status / Family

☐ Single

☐ Married Spouse's Name: ______________ Spouse is on Medicaid? Y N

☐ Widowed Spouse's Name: ______________ Spouse was on Medicaid? Y N

☐ Divorced Year of divorce: __________

Number of children: ________ Number of children in town & involved: ____________

☐ At least one child is blind or disabled Name: ______________________

Education / Military Experience

☐ High School Graduate ☐ Military Veteran ☐ WWII Veteran

Legal Documents (please bring to your appointment)

☐ Will (date: ______________) ☐ Trust (date: ______________)

☐ Power of Attorney (date: __________) Gift Provision? Y N

Named agent / attorney-in-fact: ______________________________

☐ Health Care Power of Attorney (date: ______________)

Named agent / attorney-in-fact for health care: ______________________

Health Information

Physical Health: ☐ Able ☐ Needs Periodic Help ☐ Needs Daily Help ☐ Serious

____

Mental Health: ☐ Clear ☐ Somewhat confused ☐ Very confused ☐ Totally unaware

____

Expected living situation in the next 30 days: ☐ Independent ☐ Indep. with Help

☐ Assisted Living ☐ Full Skilled Care Nursing ______________________

Expected living situation in the next 6 months: ☐ Independent ☐ Indep. with Help

☐ Assisted Living ☐ Full Skilled Care Nursing ______________________

Long Term Care Insurance

☐ Long term care coverage Company/Product: ______________________

Daily Rate: __________ Years of coverage: __________ Maximum: __________

Financial Information (Approximate values)

Assets (combine with spouse if married)

House: $__________

Car(s): $__________

Bank Accounts & CDs: $__________

IRAs / Annuities: $__________

Other Investments: $__________

Other Assets: $__________

Debts (combine with spouse if married)

Mortgage(s): $__________

Credit Cards: $__________

Other Debts: $__________

Income

Social Security: $__________ / month

Pension: $__________ / month

Other Income: $__________ / ______

Spouse's Income (if married)

Social Security: $__________ /mo.

Pension: $__________ /mo.

Other Income: $__________ / ___

Other

Number of life insurance policies: ________ Approximate total value: $ __________

Was a federal income tax return filed last year? Y N (If yes, please bring a copy)

Specific Questions You Have

____

____

____

____