This form is extremely important. Your accuracy and completeness in responding will help us best represent you. Please mail this form back to us or bring it with you to our appointment.

LONG TERM CARE ASSET AND INCOME PRESERVATION PLANNING

Name of Person filling out form: _____ Relationship to Applicant: _____

Who referred you to our firm: _____

PERSONAL DATA

Long Term Care Applicant:

Full Name _____ Known by Other Names? _____

Address _____ City/Town_____State:_____Zip Code_____

Phone: _____

Name & Address of Nursing Home: _____

Date admitted to Nursing Home: _____ Diagnosis _____

Current mental condition: _____

Date of Birth _____Age _____ US Citizen? _____ If not, immigration status? _____

Social Security Number _____

Retired? _____ (Previous) Occupation _____

Veteran? _____ Branch of service? _____ Which years did you serve? _____

Do you have any pets? If so, what kind and how many?_____

Marital status: _____

If Applicant is divorced or widowed, please give details about Applicant's spouse:

Full Name _____ Known by any Other Names _____

SS Number _____

Date of Death _____ Place of Death _____

Did your spouse ever receive Medicaid benefits? _____

Was your spouse a Veteran? _____

If yes: Branch of service? _____ Which years did he/she serve? _____

Any support or other obligations arising from previous marriage(s)? _____

APPLICANT'S CHILDREN (If applicable)
(Please list all children including any children adopted, from previous marriage, or predeceased. If you need more space, use back of the form.)

1. Child's Name _____ Present Age _____ Occupation _____
Address _____City/Town_____State_____Zip Code_____
Home Phone: _____ Cell:_____ Business:_____
E-Mail: _____
Child's Spouse's Name _____ Occupation _____
Child's Children_____ Age _____
_____ Age _____
Comments _____

2. Child's Name _____ Present Age _____ Occupation _____
Address _____City/Town_____State_____Zip Code_____
Home Phone: _____ Cell:_____ Business:_____
E-Mail: _____
Child's Spouse's Name _____ Occupation _____
Child's Children_____ Age _____
_____ Age _____
Comments _____

3. Child's Name _____ Present Age _____ Occupation _____
Address _____City/Town_____State_____Zip Code_____
Home Phone: _____ Cell:_____ Business:_____
E-Mail: _____
Child's Spouse's Name _____ Occupation _____
Child's Children_____ Age _____
_____ Age _____
Comments _____

4. Child's Name _____ Present Age _____ Occupation _____
Address _____City/Town_____State_____Zip Code_____
Home Phone: _____ Cell:_____ Business:_____
E-Mail: _____
Child's Spouse's Name _____ Occupation _____
Child's Children_____ Age _____
_____ Age _____
Comments _____

Are any children adopted? _____

Are any children from a previous marriage? _____

Are any children handicapped or in poor health?_____

Are any children receiving SSI or any other form of government entitlement? _____

Have any of Applicant's children died leaving children of their own? _____

Does the Applicant have any stepchildren from a previous marriage whom s/he wishes to include in his/her estate plan? _____

Are Applicant's parents living? Applicant's father ____ Applicant's mother _____

Does Applicant have living siblings? How many? _____

Other relatives or friends of Applicant who would be immediate beneficiaries or ultimate beneficiaries if Applicant, all children, grandchildren, and parents are deceased (use the back of this sheet if you need more space).

Name _____	_____	_____
Residence _____	_____	_____
_____	_____	_____
Age_____	_____	_____
Relation_____	_____	_____

Charities as immediate beneficiaries or ultimate beneficiaries if all individual beneficiaries are deceased.

Name_____	_____	_____
Address_____	_____	_____
_____	_____	_____
Purpose_____	_____	_____

ESTATE PLANNING PROVISIONS

Does anyone to whom Applicant may be leaving part of his/her estate require any help or protection in managing money or property? If yes, details:

_____

_____

To the Applicant:

FIDUCIARIES:
Please consider which person(s) you would like to administer your estate and care for your minor or disabled children. If you are listing anyone not listed as a family member above, please give us his or her address and phone number.

EXECUTOR OF YOUR WILL:

Primary:	_____	_____
Successor:	_____	_____

TRUSTEE(S) OF YOUR TRUST(S):

Primary:	_____	_____
Successor:	_____	_____

DISPOSITION OF YOUR ESTATE
What are your general desires as to the disposition of your estate? Indicate any specific gifts of cash or items you wish to make:

Specific Gifts	Name of Recipient	Relationship and Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

POWER OF ATTORNEY:

Have you ever given anyone a power of attorney? _____
If so, to whom and when? _____
Is it still in effect? _____

HEALTH CARE PROXY:

Have you ever given anyone the power to make health care decisions for you? _____
If so, to whom and when? _____
Is it still in effect? _____

Please consider which person(s) you would like to manage your finances and health care in the event that you are incapacitated. If you are listing anyone not listed as a family member above, please give us his or her address and phone number.

POWER OF ATTORNEY:

Primary: _____ _____

Successor: _____ _____

HEALTH CARE PROXY:

Primary: _____ _____

Successor: _____ _____

LIVING WILL:
Do you have a living will in which you express your wishes as to end-of-life decisions? _____

If not, are you interested in addressing these issues? _____

MEDICAID PLANNING PROVISIONS
GENERAL QUESTIONS

Has the Applicant or Applicant's spouse ever applied for or received medical assistance? _____

If yes, where and when? _____

Is the Applicant requesting medical assistance because of an injury, disease, or disability that was caused by someone else or that may be covered by insurance other than health insurance? _____

If yes, is any lawsuit, worker's compensation, or insurance claim pending? _____

HEALTH INSURANCE:

Please list details about any health insurance available:

Applicant:

	Claim Number	Amount of Premium	Who Pays?	Effective Date
Medicare: A? B?				
Medicare supplement:_____				
Insurance from employer				
Other: _____				

Does the Applicant have Long Term Care Insurance? _____
(if yes, please bring a copy of your policy to our meeting)

ASSETS AND LIABILITIES

INCOME

Type	Amount	How often?
Social Security/ Railroad Retirement		
Veteran's benefits		
Pensions:		
Employment		
Other:		

Is Applicant receiving any type of state or federal benefits other than retirement benefits?

If yes, details: _____

Did Applicant file US income tax returns in the past three years? _____

Does Applicant expect to receive any **inheritances**? _____ Yes ____No

If yes, from whom? _____
What is the approximate value(s)? $_____

ASSETS

NOTE: A Medicaid application asks for information about all of these categories of assets. Few applicants have all of these different types of assets. If a particular category does not apply to your family, just write "NONE". Keep in mind that we will need to disclose all assets owned within the last 60 months, even if not still owned when the application is submitted.

BANK ACCOUNTS AND SAVINGS ACCOUNTS
In this section, we need information about every bank account the Applicant currently has, including checking, savings, credit union, NOW, passbook, money-market, and CD's. We also need information about any such accounts that have been closed within the past 60 months.

Joint Accounts:

Name(s) on Acct	Name of Bank	Acct Number	Type of Acct	Current Balance	If closed, date closed

Applicant's Own Accounts:

Name(s) on Acct	Name of Bank	Acct Number	Type of Acct	Current Balance	If closed, date closed

PENSION OR PROFIT SHARING PLANS (IRAs, 401(k)s, Keoghs, etc.)
Does Applicant have any retirement accounts, including IRAs, Keoghs, or pension funds?
If yes:

Type of Plan	Owner?	Name of Company	Account Number	Fair Market Value	Beneficiary(ies)

STOCKS, BONDS, AND MUTUAL FUNDS/OTHER
In this section, we need information about any stocks, bonds, savings bonds, mutual funds, securities, assets held in safe deposit boxes, coins, stamps, and cash

# of shares	Name of Company	Description of Security	In whose name?	Fair Market Value	Basis	Amount of Income Rec'd

ANNUITIES:
Does the Applicant own any annuities? If yes:

Name of Owner	Name of Annuitant	Purchase Price	When Purchased	Income Received	Beneficiary(ies)

STOCK OPTIONS:
Does the Applicant have any stock options? If yes, please give details:

BUSINESS INTERESTS:
If the Applicant has any interest in a partnership, joint venture, closely held corporation, proprietorship or other similar entity, we need complete information about its assets and liabilities, buy-sell agreements and all other related information including basis. Use the back side of this sheet, if necessary.

LIFE AND ACCIDENTAL DEATH INSURANCE

NAME OF INSURED	INSURANCE COMPANY	POLICY NUMBER	FACE VALUE	CASH VALUE	ANY LOAN BALANCE?

TRUSTS:

Has the Applicant ever created any trust? _____

If yes, was the trust created with assets belonging to Applicant? _____

Has the Applicant transferred any properties including his/her home into a trust? _____

Has the Applicant transferred any assets into trust for a disabled child or other disabled individual? _____

Has the Applicant (or Trustee, on his/her behalf) transferred any trust assets for the benefit of anyone else? _____

Is the Applicant the beneficiary of any trust? _____

If yes, who created the trust? _____

If yes to any of above:

NAME OF TRUST	REVOCABLE OR IRREVOCABLE?	DONOR/ GRANTOR	TRUSTEE(S)	BENE-FICIARIES	WHEN CREATED?	TRUST PRINCIPAL

How much income does Applicant receive from the trust(s)? _____

REAL ESTATE:
In this section, we need information about any ownership interest the Applicant may have – or has had in the past 10 years – in any real estate, including his/her home, vacation property, rental property, time-sharing property, vacant lots, business property, whether in Massachusetts or out of state.

NAME(S) ON OWNERSHIP PAPERS	ADDRESS OF PROPERTY	TYPE	DATES OF OWNERSHIP	FAIR MARKET VALUE	PURCHASE PRICE	COST OF IMPROVE-MENTS	MORT-GAGE?

With regard to the Applicant's home:

Who lives there? _____

Relationship to Applicant: _____

If anyone other than the Applicant lives in the home, how long has he/she/they lived there?
_____

If any property listed above is rental or income producing property, how much rent do you receive? _____

PRE-PAID BURIAL OR FUNERAL PLANS:
In this section, we need information about any prepaid contract or trust or insurance policy or bank account designated for funeral and burial expenses:

NAME OF OWNER	TYPE OF PLAN	NAME OF COMPANY/BANK/ FUNERAL HOME	ACCOUNT/POLICY NUMBER	AMOUNT OF CONTRACT OR POLICY OR ACCOUNT

OTHER ASSETS:

Automobiles (model, make, fair market value, in whose name, outstanding loan?):
_____
_____

Boats, Trailers, etc. _____

Mortgages Owned, Land Contracts, or Other Receivables: _____
_____

Law suit judgments: _____

Other assets:_____
_____
_____

LIABILITIES

(including accounts payable, mortgages not listed above, promissory notes, judgments, charitable pledges)

Amount Owed	to Whom Owed	Due Date	Secured by What Asset
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GIFTS AND OTHER ASSET TRANSFERS

NOTE: We need to disclose to the Division of Medical Assistance every gift, change of asset ownership, and transfer or sale for less than fair market value that the Applicant has made in the 60 months preceding the date of application.

Has the Applicant transferred:

Income? _____

The right to income? _____

Cash? _____

Ownership in whole or in part in any other asset? _____

Create any life estate? _____

Give a mortgage? _____

Add another name to any property/account? _____

If yes to any of the above, please list:

TYPE OF ASSET	DATE OF TRANSFER	TRANSFERRED TO WHOM?	RELATIONSHIP TO APPLICANT	AMOUNT OF TRANSFER