BACH & JACOBS, P.A.
240 Pineapple Avenue, Suite 700
Sarasota, Florida 34236

BABETTE B. BACH, ESQUIRE, C.E.L.A.
Board Certified in Elder Law
Admitted in Florida and Maine
babette@sarasotaelderlaw.com

FREDRIC C. JACOBS, ESQUIRE, L.L.M.
Board Certified in Tax Law
Admitted in Florida and Pennsylvania
fred@sarasotaelderlaw.com

Phone: 941 906-1231 Fax: 941 954-1185

PLEASE COMPLETE THIS FORM TO YOUR BEST ABILITY. WE UNDERSTAND THAT THE AMOUNT OF INFORMATION REQUESTED IS EXTENSIVE AND INTRUSIVE. HOWEVER, GOVERNMENT REGULATIONS REQUIRE THAT WE PROVIDE THE ANSWERS TO ALL THE QUESTIONS CONTAINED HEREIN.

IF ASSISTANCE IS NEEDED TO COMPLETE THE FORM, WE WILL ASSIST YOU WITH ANY QUESTIONS AT YOUR FIRST MEETING.

ASSET PROTECTION PLANNING QUESTIONNAIRE
(for Married Couples)

Date:

PERSONAL INFORMATION

	HUSBAND	WIFE
Full Legal Name		
Nickname		
US Citizen?		
Age / Date of Birth		
Where were you born?		
Social Security Number		
Home Address		
County of Residence		
Home Telephone		
Business Telephone / Fax		
Cell:		
E-Mail Address		
Employer		

Are you planning on moving to another state? **Yes_____ No_______**	**NOTICE: THIS FIRM CAN ADVISE YOU AS TO FLORIDA MEDICAID LAW AND RULES ONLY.**

Is the client(s) in, or expected to enter, a Nursing Home? If so list name of facility and approximate date of admission:____

Please describe client's current health condition:____

MARITAL INFORMATION

	HUSBAND	WIFE
Date of Marriage		
Where Married		
Which Marriage is this for you?		
Have you ever signed a pre- or post-marriage contract?		
Are you or your spouse financially obligated to anyone due to dissolution of marriage or support action suit?		

IMPORTANT FAMILY QUESTIONS

(Circle Yes or No for your answer. Explain yes answer below. Please use additional pages if necessary)	HUSBAND		WIFE	
1. Do you have any children or grandchildren with learning or other disability?	Yes	No	Yes	No
2. Do you or any of your children receive governmental support or benefits?	Yes	No	Yes	No
3. Do any of your children or grandchildren have special educational, medical, or physical needs?	Yes	No	Yes	No
4. Is any member of your family institutionalized?	Yes	No	Yes	No
5. Are you receiving social security, disability or other governmental benefits?	Yes	No	Yes	No
6. Do you provide primary or other major financial support to adult children?	Yes	No	Yes	No
7. Have you ever filed a federal or state gift tax return?	Yes	No	Yes	No
8. Are any of your children or grandchildren in the process of, or likely to be getting a divorce?	Yes	No	Yes	No
9. Are any of your children or grandchildren in serious credit trouble?	Yes	No	Yes	No
10. Are your children or grandchildren in occupations that have a high risk of being sued?	Yes	No	Yes	No
11. Do any of your children or grandchildren have problems managing money well?	Yes	No	Yes	No
12. Are you a Veteran?	Yes	No	Yes	No
13. Do you have a system in place to keep all your personal and financial records up to-date and organized?	Yes	No	Yes	No
14. Do you have an existing or previous will, trust, or estate plan? ***(Please bring copies of these documents to the interview if at all possible.)***	Yes	No	Yes	No

CHILDREN or NEXT OF KIN

CHILD or NEXT of KIN Natural or Legally Adopted [ ]Husband's [ ] Wife's [ ] Both			
Full Legal Name			
Birth date		Age	
Address City, State, Zip			
E-mail Address			
Child's Spouse's name		Telephone Number	( )
Children (your grandchildren)	Name		Age
Does child manage money well?			
Relationship w/parents			
Relationship w/ siblings			
Any special needs or considerations or other comment about this family?			

CHILD or NEXT of KIN Natural or Legally Adopted [ ]Husband's [ ] Wife's [ ] Both			
Full Legal Name			
Birth date		Age	
Address City, State, Zip			
E-mail Address			
Child's Spouse's name		Telephone Number	( )
Children (your grandchildren)	Name		Age
Does child manage money well?			
Relationship w/parents			
Relationship w/ siblings			
Any special needs or considerations or other comment about this family?			

CHILD or NEXT of KIN Natural or Legally Adopted [ ]Husband's [ ] Wife's [ ] Both			
Full Legal Name			
Birth date		**Age**	
Address **City, State, Zip**			
E-mail Address			
Child's Spouse's name		**Telephone Number**	( )
Children (your grandchildren)	**Name**		**Age**
Does child manage money well?			
Relationship w/parents			
Relationship w/ siblings			
Any special needs or considerations or other comment about this family?			

PERSONAL PLANNING INFORMATION		
If you have the following documents, it is imperative that you bring a copy to the meeting		
DOCUMENT	STATE	DATE
Last Will and Testament		
Durable Power of Attorney		
Living Will and/or Trust		
Health Care Power		

Notes for Attorney: ______________________________

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HEALTH & LONG-TERM CARE INSURANCES			
LONG-TERM CARE (NURSING HOME) INSURANCE			
Insurance Carrier/Policy Number	Insured	Type of Insurance	Daily Benefit And Term (for nursing home insurance)
Address and Phone No.			

HEALTH INSURANCE			
MEDIGAP POLICY (Supplemental Health Insurance)	Insured	Policy/ Group #	Monthly Premium
Name of Company/Address/Phone No.			

MEDICARE (PART D) PRESCRIPTION PLAN			
Name and Address of Company	Insured	Policy/ Group #	Monthly Premium

GROSS MONTHLY INCOME		
INCOME SOURCE	**HUSBAND**	**WIFE**
Social Security		
Pension		
Gross wages from employment		
Interest on Bank Accounts, savings accounts, CDs		
Dividends on stocks and bonds		
IRAs		
Annuity payments		
Income from rental property or business		
U.S. Civil Service (pension paid out from government (U.S., State, County or City) offices)		
Military Retired Pay		
Supplemental Social Security Income		
Other		
TOTAL MONTHLY INCOME	**$____________**	

Notes for Attorney: ____

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HOUSEHOLD ASSETS

ASSETS	Husband (Value of Asset)	Wife (Value of Asset)	Joint (Value of Asset)	Comments/ Account #/Policy #
Checking account(s)				
Savings Account(s)				
Stocks and Bonds				
Retirement Plan(s) (401 K, Roth IRA, etc)				
Money Market Accounts				
Certificates of Deposit				
Life insurance policies (cash surrender value)				
Annuities				
Investment Account(s)				
Anticipated Inheritance, Gift or Judgment				
Trust Fund				
Automobile	**Model/Year:**			
Personal Residence Do you intend to sell your primary residence in next 10 years?	**Address:** Yes/No			
Other Real Property:	**Address:**			
Secured Notes (money owed to you)				

ASSETS	**LOCATION**	**VALUE**	**TITLE (Husband, Wife or Joint)**	**Account # / Policy #**
Business interest				
Other Assets				
TOTAL ASSETS				

Notes for Attorney: ______________________________

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LIABILITIES	**HUSBAND**	**WIFE**	**ACCOUNT#**
Loans payable			
Accounts payable			
Real Estate Mortgages			

Please complete this only if your spouse's gross monthly income is less than $1,821.00/month.
HOUSING EXPENSES

Rent or mortgage	
Real Estate Taxes	
Condo/Association Fees	
Home Insurance	
Gas	
Electric	
Water & Sewer	
TOTALS	

GIFTS MADE WITHIN MEDICAID LOOK-BACK PERIOD

A. Have you or your spouse made any outright gifts or transfers, greater than $500.00, to any individuals other than each other or to a Trust within the last sixty (60) months? ___________ If yes, please complete the following (use the back if necessary).

Recipient # 1		**Recipient # 3**	
Date of Gift		**Date of Gift**	
Item		**Item**	
Value		**Value**	
Recipient # 2		**Recipient #4**	
Date of Gift		**Date of Gift**	
Item		**Item**	
Value		**Value**	

If you have liquidated assets for Medicaid planning please complete this section. If you have only liquidated assets for your personal support please ignore this section.

Please list name, address, policy and/or account numbers, values of the closed accounts or liquidated assets within the 60 months Medicaid look-back period. Also provide information concerning where the liquidated funds were deposited and what they were used for.

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UNPAID MEDICAL BILLS

Do you have any unpaid medical expenses for the prior three months? Yes____ No____

Today's Date: ______________________________

Client's Signature: __________________________