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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 Single Client)

Date:

PERSONAL INFORMATION

	CLIENT
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 phone	
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 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:____

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IMPORTANT FAMILY QUESTIONS		
(Circle Yes or No for your answer. Explain yes answer below. Please use additional pages if necessary)	CLIENT	
1. Do you have any children or grandchildren with learning or other disability?	**Yes**	**No**
2. Do you or any of your children receive governmental support or benefits?	**Yes**	**No**
3. Do any of your children or grandchildren have special educational, medical, or physical needs?	**Yes**	**No**
4. Is any member of your family institutionalized?	**Yes**	**No**
5. Are you receiving social security, disability or other governmental benefits?	**Yes**	**No**
6. Do you provide primary or other major financial support to adult children?	**Yes**	**No**
7. Have you ever filed a federal or state gift tax return?	**Yes**	**No**
8. Are any of your children or grandchildren in the process of, or likely to be getting a divorce?	**Yes**	**No**
9. Are any of your children or grandchildren in serious credit trouble?	**Yes**	**No**
10. Are your children or grandchildren in occupations that have a high risk of being sued?	**Yes**	**No**
11. Do any of your children or grandchildren have problems managing money well?	**Yes**	**No**
12. Are you a Veteran?	**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**
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**

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	**CLIENT**
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	LOCATION	VALUE	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	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			

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, value 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: __________________________