Penbay Estate Planning Law Center
a LifeCounsel® Law Firm

MEDICAID ELIGIBILITY PLANNING INTAKE FORM

SINGLE PERSON

Information of individual completing this form:

Name:	
Company:	
Address:	
City, State, Zip:	
Telephone:	
Facsimile:	
E-Mail:	

ONCE COMPLETED, RETURN THIS FORM TO:

Penbay Estate Planning Law Center
PO Box 1254 Camden Maine 04843
Phone: (207)236-4888
help@penbaylaw.com

A. CLIENT DATA

Client Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

U. S. Citizen? ☐ Yes ☐ No
Veteran? ☐ Yes ☐ No Surviving Spouse of Veteran? Yes ☐ No ☐

B. MEDICAL DATA

Diagnosis: _____

Residence of Individual: ☐ Home ☐ Nursing Home ☐ Assisted Living Facility

If individual has already entered a care facility, please indicate the first date he or she entered on a continuous basis: _____

County the Medicaid applicant will be applying for benefits: _____

C. RESPONSIBLE PARTY(IES)

Please provide information regarding the medicaid applicant's children, Power of Attorneys (POA), beneficiaries, or other responsible party(ies).

NAME	RELATIONSHIP	PHONE NUMBER	STATE OF RESIDENCE

Are any of the individuals named above the primary POA for the Medicaid applicant? ☐Yes ☐No If yes, please name the individual(s): _____

_____

Are any of the individuals named above interested in learning more about Long-Term Care Insurance in order secure their own financial future? ☐Yes ☐No

If yes, please name the individual(s): _____

_____

If any individuals indicate they are interested in learning more about Long-Term Care Insurance, they may be contacted by a Long-Term Care Insurance Advisor within or associated to our office.

D. MONTHLY INCOME

Social Security Benefit $_____

Pension (Gross) $_____

VA Disability Benefit $_____

Other Income* $_____

Total Monthly Income $_____

*If other, please explain: _____

_____

_____

Do not include interest and dividend income on this form. If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

E. MONTHLY COST OF CARE

$_____ Monthly Facility Cost

$_____ Health Insurance Premiums

$_____ Medicare Supplemental Insurance Premiums

$_____ Monthly Incidental Cost

$_____ Monthly Prescription Cost

$_____ Monthly Other Cost

$_____ Total Monthly Costs

The care facility is paid through _____(month/year).

As such, if applicable, please provide the Medicaid per diem rate: $_____

F. ASSETS/LIABILITIES

Please insert the value of each asset/liability in the appropriate space. Specify whether multiple accounts or one account for each type of asset.

Asset	Value	Liability
AUTOMOBILE		
ADDITIONAL AUTOMOBILE		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
OTHER BANK ACCOUNTS		
RESIDENCE		
MUTUAL FUNDS		
STOCKS/BONDS		
ANNUITIES		
RETIREMENT ACCOUNTS		
ROTH IRAs		
OTHER REAL ESTATE		
CARE FACILITY DEPOSIT		
OTHER		
OTHER		
OTHER		
OTHER		
TOTAL		

Does the Medicaid applicant own an irrevocable Funeral Expense Trust? ☐Yes ☐No

If the Medicaid applicant owns a home, will the home be sold or gifted as part of the Medicaid plan?

☐Yes ☐No If yes, please explain: _____

Are there any additional liabilities that should be considered (credit card debt, personal loans, outstanding medical bills, etc.)? ☐Yes ☐No If yes, please explain: _____

_____

G. LIFE INSURANCE

TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call the insurance agent, or call the insurance company directly.

H. GIFTS

Has the Mainecare applicant made gifts in excess of $100.00 in any one month, to an individual or group of individuals, within the past 60 months? ☐Yes ☐No

If yes, please explain: _____

_____

_____

J. CERTIFICATION

The undersigned hereby represents to Penbay Estate Planning that the information contained in this intake form is accurate and complete, and that the undersigned understands that Penbay Estate Planning will rely on this information for purposes of developing a Medicaid Annuity plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Medicaid eligibility.

Dated: _____

Signature of Client or Client Representative: _____