THE LARSON LAW FIRM, P.C.
ESTATE PLANNING, TAX, TRUST AND ESTATE ADMINISTRATION

MEDICAID PLANNING SURVEY

DATE:_____

YOUR NAME:_____

HOME PHONE:_____BUSINESS PHONE:_____

NAME OF MEDICAID APPLICANT:_____

APPLICANTS HOME ADDRESS OR NURSING HOME ADDRESS:_____

_____

IF IN NURSING HOME, DATE OF ADMISSION:_____

APPLICANTS PHONE:_____NURSING HOME PHONE:_____

SOCIAL SECURITY #:_____DATE OF BIRTH:_____

DATE OF MARRIAGE:_____REFERRED BY:_____

SPOUSE:

NAME:_____DATE OF BIRTH:_____

SOCIAL SECURITY #:_____IF DECEASED, DATE OF DEATH:_____

RESIDENCE ADDRESS, IF DIFFERENT:_____

_____

HOME PHONE:_____BUSINESS PHONE:_____

NAMES, ADDRESS AND TELEPHONE NUMBERS OF CHILDREN, IF ANY:

_____

_____

_____

_____

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Voice 503.742.1821 ▪ Fax 503.742.1827 ▪ 1.800.908.8787 ▪ mail@thelarsonlawfirm.com

(The following questions apply to the applicant)

FAMILY ASSETS:

TYPE OF OWNERSHIP: (J=JOINT) (H=HUSBAND) (W=WIFE)

DO YOU OWN YOUR OWN HOME? ☐ YES ☐ NO

IF YES, TYPE OF OWNERSHIP: ☐ J ☐ H ☐ W

ADDRESS AND APPROXIMATE VALUE:_____

$_____ _____

BANK ACCOUNTS:

LIST ALL TYPES OF BANK ACCOUNTS HELD DURING THE PAST 36 MONTHS:

NAME OF BANK	ACCOUNT #	OWNERSHIP	APPROX. BALANCE / OR DATE CLOSED

LIFE INSURANCE:

COMPANY	POLICY	OWNER	FACE VALUE	CASH SURRENDER VALUE

OTHER ASSETS NOT LISTED ABOVE – ANNUITIES, STOCKS, BONDS, IRA'S:

_____

_____

_____

_____

_____

TRANSFERS:

HAVE YOU TRANSFERRED ANY PROPERTY WITHIN THE PAST 36 MONTHS? ☐ **YES** ☐ **NO**

IF YES:

TYPE OF PROPERTY	VALUE	TRANSFERRED TO:

INCOME:

	APPLICANT	SPOUSE
SOCIAL SECURITY:	_____	_____
PENSION:	_____	_____
VETERAN BENEFITS:	_____	_____
INTEREST INCOME:	_____	_____
DIVIDENDS:	_____	_____
ANNUITIES:	_____	_____
OTHER:	_____	_____

ARE YOU A VETERAN? ☐ YES ☐ NO

SPOUSE ☐ YES ☐ NO

DO YOU HAVE A PREPAID FUNERAL? ☐ YES ☐ NO

IF YES, NAME OF FUNERAL DIRECTOR:_____

DO YOU HAVE A BURIAL PLOT? ☐ YES ☐ NO

DO YOU OWN AN AUTOMOBILE? ☐ YES ☐ NO

DO YOU HAVE A SAFE DEPOSIT BOX? ☐ YES ☐ NO

DO YOU HAVE A POWER OF ATTORNEY? ☐ YES ☐ NO

IF YES, HELD BY WHOM?_____

DO YOU HAVE A HEALTH PROXY? ☐ YES ☐ NO

DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO

ARE YOU EXPECTING AN INHERITANCE? ☐ YES ☐ NO

DO YOU HAVE MEDICARE? ☐ ***YES*** ☐ ***NO***

ID#:_____ PART A:_____ PART B:_____

DO YOU HAVE PRIVATE HEALTH INSURANCE? ☐ ***YES*** ☐ ***NO***

COMPANY ID MONTHLY PREMIUM

_____

_____

_____

ADDITIONAL INFORMATION:

_____

_____

_____

_____

MONTHLY LIVING EXPENSES

Rent/Mortgage:	_____
Heat:	_____
Electricity:	_____
Telephone:	_____
Water / Sewer:	_____
Garbage:	_____
Property taxes:	_____
Property repairs / maintenance:	_____
Auto insurance:	_____
Auto maintenance / gas:	_____
Health Insurance:	_____
Medications:	_____
Misc. medical expenses:	_____
Life / Annuity premiums:	_____
Food / Household supplies:	_____
Entertainment:	_____
Other (please specify):	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

TOTAL EXPENSES: _____