SULLIVAN & SULLIVAN, P.C.

ATTORNEYS AT LAW

James C. Sullivan
Donna S. Madden
Elizabeth F. Sullivan
Leo J. Sullivan (1931 –2007)

The Meadows, 1130 Ten Rod Road, Suite B-206
North Kingstown, Rhode Island 02852
Telephone 401 294-9556
Fax 401 294-9561

Robert H. Breslin, Jr.
Of Counsel

Albert D. Saunders, Jr.
Of Counsel

www.SullivanLawRI.com

ASSET PRESERVATION / MEDICAID QUESTIONNAIRE (MARRIED)

Today's Date_____ File Number_____(Office Use Only)

Your accuracy in completing this form is very important. Please bring this information with you to the appointment.

A. PERSONAL DATA

(Husband) **(Wife)**

Full Name_____ Full Name_____

Street Address_____

City_____ State_____ Zip_____

Home Phone No._____ Cell Phone No._____

Email address: _____

(**Husband**) (**Wife**)

Birth Date_____ Birth Date_____

Social Security No._____ Social Security No._____

U.S. Citizen? Yes☐ No☐ U.S. Citizen? Yes☐ No☐

Veteran? Yes☐ No☐ Veteran? Yes☐ No☐

If you are a Veteran who served at least one (1) day during war time, you may qualify for a Veteran's Aid and Attendance Pension.

B. MEDICAL INFORMATION

1. HEALTH

Name of Ill Spouse_____

Diagnosis_____

Prognosis_____

Course of Treatment_____

If Ill Spouse is already in a nursing home:

Name of nursing home:_____
Address: _____
Date of Admission: _____
Daily Rate: _____

Was admittance to the nursing home preceded by a hospital stay? ____Yes ___No

If Yes, please identify hospital and date of admittance:
_____

Name of Well Spouse: _____

Health of Well Spouse_____

Residence of Well Spouse _____

2. PHYSICIAN

(Husband)

Name of Primary Physician _____
Address_____
City_____ State_____ Zip_____
Tel: _____

(Wife)

Name of Primary Physician _____
Address_____
City_____ State_____ Zip_____
Tel: _____

C. **MONTHLY INCOME**	Husband	Wife
Gross Social Security	$_____	$_____
Deductions: (Medicare)	_____	_____
Retirement Benefits	$_____	$_____
Deductions:(ins, taxes, dues)	_____	_____
	_____	_____
VA Disability Benefit	$_____	$_____
Annuity Income	$_____	$_____
Rental Income	$_____	$_____
TOTAL MONTHLY INCOME	**$_____**	**$_____**

D. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost	$_____
Monthly Other Cost	$_____
Total Monthly Cost	**$_____**

E. MONTHLY SHELTER EXPENSES **(If paid annually divide by 12; quarterly divide by 4)**

Rent/Mortgage	$_____
Real Estate Taxes	$_____
Water	$_____
Sewer	$_____
Utilities (Heat, Electric & Tel)	$_____
Homeowner's insurance premium	$_____
Condominium fees	$_____
Total Monthly Housing Expenses	**$_____**

F. MONTHLY NON-SHELTER LIVING EXPENSES

Food	$_____
Medical	$_____
Clothing	$_____
Transportation (gas, insurance, car payments)	$_____
Home Maintenance (lawn, snow)	$_____
Life Insurance Premiums	$_____
Health Insurance Premiums	$_____
Cable, Internet	$_____
Federal and State Income Taxes	$_____
Other	$_____

Total Monthly Non-Shelter Living Expenses $_____

G. GIFTS

Please list all gifts made to an individual or individuals, within the past 60 months:

Recipient_____ Date_____ Amount_____

Recipient_____ Date_____ Amount_____

Recipient_____ Date_____ Amount_____

Recipient_____ Date_____ Amount_____

Have you ever filed a Federal Gift Tax Return? Yes☐ No☐

If so, please state details _____

_____

H. LIFE INSURANCE

Company Name Policy #	Type:Whole or Term	Death Benefit Value	Face Value	Cash Value	Insured	Owner	Benificiary

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

G. LONG TERM CARE INSURANCE

Do you have Long Term Care Insurance in effect Yes □ No □

If yes, please provide information and copy of policy

H. CHILDREN (if applicable)

CHILD'S NAME	ADDRESS/ZIP	TELEPHONE #	DATE OF BIRTH	SOCIAL SECURITY #

Does the Husband have any children by a previous marriage? Yes_____ No _____

Does the Wife have any children by a previous marriage? Yes_____ No_____

Are all of your children in good health? Yes_____ No_____

Are any of your children blind or disabled? Yes_____ No_____

Are any of your children receiving SSI or other form of government entitlement? Yes_____ No_____

Are any of your children or other family members living with a chronic disease or terminal illness? Yes_____ No_____

Do any of your family members have any problems with:

Drug Addiction? Yes___ No___
Alcoholism? Yes___ No___
Spendthrift? Yes___ No___

Do any of your relatives (children, siblings, etc.) live with you in your home? Yes_ No_
If yes, name of relative_____

I. CLIENT ASSET INFORMATION

PERSONAL PROPERTY

(Autos, Mobile Homes, R.V.s, Boats, Art, Antiques, Jewelry)

Description of Property Value Owner/Title

_____
_____
_____
_____
_____

TOTAL VALUE OF PERSONAL PROPERTY: $_____

REAL ESTATE

For each listing, indicate type of property, i.e., condominium, co-op, mobile home, timeshare, land, single residence, multifamily residence, etc.

Primary Residence:
Address:_____
_____
Type of Property: _____
Owner/title:_____
Date acquired:_____
Purchase Price:_____
Current Value:_____
Mortgage Balance:_____
Lender:_____
Improvements: Date:_____Cost:_____
Real Estate Tax:_____
Exemptions: _____

Investment Property :
Address:_____
_____
Type of Property: _____
Owner/title:_____
Date acquired:_____
Purchase Price:_____
Current Value:_____
Mortgage Balance:_____
Lender:_____
Improvements: Date:_____ Cost:_____
Real Estate Tax:_____
Exemptions: _____

Total value of real estate: $________________________
Less outstanding mortgages: $_____________________
Equity in real estate: $____________________________

INTANGIBLE ASSETS

List Bank Accounts (including custodial accounts), CDs, Brokerage Accounts, Stocks, Bonds, Annuities, Mutual Funds. This section must be completed in full. Please bring the most recent statement for each asset to the appointment. <u>If the asset is an IRA, Keogh or 401(k) plan, please list in the next section.</u>

Type of Account:____
Name of Financial Institution:__________________________________
Address: ____ Tel.______________
Name of Broker/Agent: _______________________________
Ownership/Title: ____
Value: $_______________ Account #:____________________
Beneficiary:________________________
Maturity date?:_________ Interest rate:____________
Annual interest earned?__________

Type of Account:____
Name of Financial Institution:__________________________________
Address: ____ Tel.______________
Name of Broker/Agent: _______________________________
Ownership/Title: ____
Value: $_______________ Account #:____________________
Beneficiary:________________________
Maturity date?:_________ Interest rate:____________
Annual interest earned?__________

Type of Account:____
Name of Financial Institution:__________________________________
Address: ____ Tel.______________
Name of Broker/Agent: _______________________________
Ownership/Title: ____
Value: $_______________ Account #:____________________
Beneficiary:________________________
Maturity date?:_________ Interest rate:____________
Annual interest earned?__________

Type of Account:____
Name of Financial Institution:__________________________________
Address: ____ Tel.______________
Name of Broker/Agent: _______________________________

Ownership/Title: _____
Value: $_____ Account #:_____
Beneficiary:_____
Maturity date?:_____ Interest rate:_____
Annual interest earned?_____

Total intangible assets:$_____

IRA, KEOGH AND/OR 401(K) PLANS

Type of Account:_____
Name of Financial Institution:_____
Address: _____ Tel._____
Name of Broker/Agent: _____
Ownership/Title: _____
Value: $_____ Account #:_____
Beneficiary:_____
Maturity date?:_____ Interest rate:_____Annual interest:_____
Death benefit_____
Minimum distribution:_____

Type of Account:_____
Name of Financial Institution:_____
Address: _____ Tel._____
Name of Broker/Agent: _____
Ownership/Title: _____
Value: $_____ Account #:_____
Beneficiary:_____
Maturity date?:_____ Interest rate:_____ Annual interest:_____
Death benefit_____
Minimum distribution:_____

Type of Account:_____
Name of Financial Institution:_____
Address: _____ Tel._____
Name of Broker/Agent: _____
Ownership/Title: _____
Value: $_____ Account #:_____
Beneficiary:_____
Maturity date?:_____ Interest rate:_____ Annual interest: _____
Death benefit_____
Minimum distribution:_____

Total IRA, Keogh or 401(k) assets: $_____

TOTAL OF ALL ASSETS: $_____
(Add totals of personal property, real estate, intangible assets and retirement accounts)

LIABILITIES

Mortgages: $_____ Car Loans: $_____
Unpaid Medical: $_____ Other $_____
Credit Card Bills: $_____

Total Liabilities: $_____

J. REFERRAL

By Whom Were You Referred To This Office?

Name_____

Street Address_____

City_____ State_____ Zip_____

Tel. _____

K. CERTIFICATION

The undersigned hereby represents to Sullivan & Sullivan, P.C., and each of its attorneys that the information contained in this intake form is accurate and complete, and that the undersigned understands that the law firm and its individual lawyers will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client(s) or Client Representative:

_____

_____

Would you please tell us how you heard about Sullivan & Sullivan: _____
_____