

## Long-Term Care Planning

Thank you for engaging me to discuss your elder care needs. I look forward to working with you in regards to planning for your future healthcare and appreciate the confidence you have placed in me.

Attached is my Long-Term Care Planning questionnaire. The LegalJourney Law Firm, PLLC recognizes that the information requested in this questionnaire is highly personal. Please be assured that all information provided shall be kept confidential in accordance with the attorney/client privilege as required by the Rules Regulating The Florida Bar, Chapter 4. Rules of Professional Conduct.

The purpose of this questionnaire is to gain as much information in advance to minimize time delays and to maximize the advice I am able to give you during our initial consultation. Please fill out the questionnaire as completely as possible on your own and we can work together to fill in any 'gaps' as needed.

Again, I appreciate the opportunity to work with you in connection to this matter and look forward to a mutually satisfactory relationship.

Regards,



Karnardo Garnett, Esquire  
Attorney at Law

Enclosure

# Welcome!



**Estate Planning**  
**Elder Law ♦ Asset Protection ♦ Medicaid**  
**Probate**

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You are about to begin the process of Long Term Care Planning. In order for us to make this process more pleasant for you, we must begin by obtaining as much information as possible regarding your personal estate. Although this questionnaire covers a lot of information, it is necessary to the estate planning process and its completion will enable us to keep costs down for you

The following questions are designed to facilitate this process -- *not to intimidate you*. Please answer all of the questions to the best of your ability. Although you should not spend an inordinate amount of time gathering the information, we have found that having this data available at the initial conference greatly aids both you and us in focusing on planning issues. If you do not have certain information, you may notify us at a later date.

- If a certain question does not pertain to you, enter “**N/A.**”
- If certain information is the same for the spouses, please enter “**Same.**”
- If you need more space, please attach a separate page with the number and question you are responding to and type or write the information.
- **When you have completed the form to the best of your ability, please return it to our firm via facsimile, regular mail, or electronic mail (after scanning it), leaving plenty of time for us to receive it.**

*If you have any problems using this form or understanding certain questions, please feel free to contact our office.*

**Let's get started!**

# ASSET PROTECTION & MEDICAID PLANNING QUESTIONNAIRE

**THIS INFORMATION IS EXTREMELY IMPORTANT TO ENABLE US TO SERVE YOU. IF ASSISTANCE IS NEEDED TO COMPLETE THE FORM, PLEASE CALL US.**

Throughout this Questionnaire, please use the back of each page to write additional information.

Date: \_\_\_\_\_

I. Name of Medicaid Applicant: \_\_\_\_\_

A. Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

B. U.S. Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_ Military Service \_\_\_\_\_

C. Telephone Number: \_\_\_\_\_

D. Home Address: \_\_\_\_\_  
\_\_\_\_\_

E. If not at home, give name and address of residency:

\_\_\_\_\_  
\_\_\_\_\_

F. Date of Admission to Nursing Home/Assisted Living Facility:

\_\_\_\_\_

G. Medical condition/illnesses \_\_\_\_\_

\_\_\_\_\_

H. Can applicant do the following activities without major assistance?

1. Walk or Stand: Yes \_\_\_\_\_ No \_\_\_\_\_

2. Feed self: Yes \_\_\_\_\_ No \_\_\_\_\_

3. Clothe self: Yes \_\_\_\_\_ No \_\_\_\_\_

4. Bathe self: Yes \_\_\_\_\_ No \_\_\_\_\_

5. Incontinent: Yes \_\_\_\_\_ No \_\_\_\_\_

6. Partially paralyzed: Yes \_\_\_\_\_ No \_\_\_\_\_

If no, detail: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

7. Does Applicant have Dementia (memory loss, lack rational conversation)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, detail extent: \_\_\_\_\_

8. Applicant's Primary Health Insurance: \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_

Premium per month: \_\_\_\_\_

9. Primary Care Doctor: Name, Address and Telephone Number: \_\_\_\_\_  
\_\_\_\_\_

II. Spouse's Name: \_\_\_\_\_

A. Address: \_\_\_\_\_  
\_\_\_\_\_

B. Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

C. U.S. Citizen: Yes \_\_\_\_\_ No \_\_\_\_\_ Military Service \_\_\_\_\_

D. Telephone Number: \_\_\_\_\_

E. Is this a first marriage? Yes \_\_\_\_\_ No \_\_\_\_\_

If not a first marriage, is there a pre or post nuptial agreement?

Pre nuptial: Yes \_\_\_\_\_ No \_\_\_\_\_ Post nuptial: Yes \_\_\_\_\_ No \_\_\_\_\_  
(If so, bring copy) (If so, bring copy)

F. Can spouse do the following activities without major assistance?

- |                         |                    |
|-------------------------|--------------------|
| 1. Walk or Stand:       | Yes _____ No _____ |
| 2. Feed self:           | Yes _____ No _____ |
| 3. Clothe self:         | Yes _____ No _____ |
| 4. Bathe self:          | Yes _____ No _____ |
| 5. Incontinent:         | Yes _____ No _____ |
| 6. Partially paralyzed: | Yes _____ No _____ |

If no, detail: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Does Applicant's spouse have Dementia (memory loss, lack rational conversation)?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, detail extent: \_\_\_\_\_

8. Primary Health Insurance: \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_

Premium per month: \_\_\_\_\_

III. Children

A. Names, addresses and telephone numbers of each of applicant's children:

1. \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_

4. \_\_\_\_\_  
\_\_\_\_\_

B. Names, addresses and telephone numbers of each of spouse's children (if same as applicant's mark "same"):

1. \_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_

3. \_\_\_\_\_  
\_\_\_\_\_

4. \_\_\_\_\_  
\_\_\_\_\_

C. Are any of Applicant's or Applicant's spouse's children or grandchildren disabled?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, does the individual receive Supplemental Security Income?

Yes \_\_\_\_\_ No \_\_\_\_\_

Does the individual receive Social Security Disability Income?

Yes \_\_\_\_\_ No \_\_\_\_\_

Name of disabled individual(s) and the disability—relationship to Applicant or Applicant's spouse

\_\_\_\_\_

\_\_\_\_\_

D. Does Applicant have a Will or Trust?

Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse? Yes \_\_\_\_\_ No \_\_\_\_\_

(If so, bring copies)

E. Has Applicant executed a power of attorney?

Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse? Yes \_\_\_\_\_ No \_\_\_\_\_

(If so, bring copies)

If yes, who is named on Applicant's? \_\_\_\_\_

Spouse's? \_\_\_\_\_

F. Has Applicant executed a living will and health care surrogate (proxy) designation?

Yes \_\_\_\_\_ No \_\_\_\_\_

Spouse? Yes \_\_\_\_\_ No \_\_\_\_\_

(If so, bring copies)

If yes, who is designated on Applicant's? \_\_\_\_\_

Spouse's? \_\_\_\_\_

IV. INCOME

A. Applicant's:

Source

Gross Social Security monthly benefit \$ \_\_\_\_\_

Gross Monthly pension (from whom?) \$ \_\_\_\_\_

Gross Monthly pension (from whom?) \$ \_\_\_\_\_

Gross Monthly pension (from whom?) \$ \_\_\_\_\_

Detail other income except for interest and dividends \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

B. Spouse:

Source

Gross Social Security monthly benefit \$ \_\_\_\_\_

Gross Monthly pension (from whom?) \$ \_\_\_\_\_

Gross Monthly pension (from whom?) \$ \_\_\_\_\_

Gross Monthly pension (from whom?) \$ \_\_\_\_\_

Detail other income except for interest and dividends \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

C. Has Applicant or Applicant's spouse applied for Veteran's benefits?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, is either receiving benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Amount receiving? \_\_\_\_\_

If yes, what type of benefit? \_\_\_\_\_

V. ASSETS







4. Are any of the Properties encumbered by a Mortgage?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Property Address: \_\_\_\_\_

Principal Balance: \_\_\_\_\_

Property Address: \_\_\_\_\_

Principal Balance: \_\_\_\_\_

E. Applicant's and Spouse's Debts

Whose Debt?	Type of Debt (credit card, notes, etc.)	Company	Balance	Payments

F. Debts owed to Applicant and Spouse

To whom owed	Type of Debt	Debtor	Balance	Payments

G. Cars (list manufacturer and model year of cars)

Manufacturer	Year	Title	(In Whose Name?)

H. Any special collectibles? \_\_\_\_\_

VI. GIFTS

A. Has applicant or spouse made any gifts or transfers to any person in the last 5 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

B. Has any joint account holder taken funds from joint accounts in the last 5 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, to either Question A and/or Question B above complete the following:



## **MEDICAID APPLICATION: ITEMS NEEDED**

Kindly gather the following list of items, and have ready to present to the attorney in preparation for meeting with the Medicaid case worker at the interview held after application is filed.

Start gathering the forms and information **now**. Do not wait until the last moment before the interview. If you can't find all the forms or information or some of the items listed that do pertain to you, see your attorney or legal assistant at this office for advice.

- A. Photo I.D. of Applicant and spouse (i.e., driver's license, state issued ID card).
- B. Social Security card.
- C. Birth records and marriage records.
- D. Passports, even if expired.
- E. Military discharge papers (if applicable).
- F. Death certificate for spouse (if applicable).
- G. Alien registration or naturalization papers.
- H. Medicare Card or HMO card and cards from any health insurance plan along with recent premium notice.
- I. Social Security Administration statements of benefits for husband and wife.
- J. Benefit statements from Veterans Administration and Pension funds, stating **gross** monthly amount.
- K. Life insurance policies and statements showing current cash surrender values.
- L. Deeds to all property **wherever** located on which applicant or applicant's spouse's name appear.
- M. Real Estate tax bill ( the most current ones available) for each property.
- N. Contracts for sale of real estate.
- O. Closing statements for property sold within past 5 years.
- P. Leases and rent schedules (or letter from landlord).
- Q. Title or registration for cars, mobile homes and boats owned.
- R. Contracts for burial plots and funeral arrangements along with irrevocable statement from funeral home.
- S. The most recent bank statements on **all** bank accounts on which applicant or applicant's spouse's name appear (for last 3-4 months) i.e. checking, savings, money markets, CDs, along with copies of checks.
- T. Statements from your stock brokers for past three (3) months or listing of any stocks and bonds owned and market values (show who owns what).

- U. Statements on any brokerage money market accounts on which applicant or applicant's spouse's name appear.
- V. If working, proof of income earned during past 2 months (8 weeks).
- W. Annuity contracts owned by you for which you receive payments.
- X. Mortgages and promissory notes you own and for which you receive payment.
- Y. Income tax returns for past three (3) years (if applicable).
- Z. Intangible tax returns for past three (3) years (if applicable).
- AA. Last bill for homeowner's or condo insurance.
- BB. Condominium or homeowner's association maintenance charges (bills or coupons).
- CC. Utility bills (electricity, gas, water, sewage and waste management and water)—**not** telephone.
- DD. Proof as to unemployment compensation or worker's compensation received.
- EE. Proof of legal guardianship, if applicable.
- FF. Contracts with care providers.

I certify that the above information is a true and accurate representation of all assets and income of both applicant and applicant's spouse. Should any information be omitted or incorrect I hold harmless the LegalJourney Law Firm PLLC, its attorneys, legal assistants and staff from all liability resulting from said omission or incorrect information.

\_\_\_\_\_  
APPLICANT/POWER OF ATTORNEY

\_\_\_\_\_  
APPLICANT'S SPOUSE/POWER OF ATTORNEY