McKinley Law Group, LLC

ASSET PROTECTION PLANNING QUESTIONNAIRE

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

A. PERSONAL DATA

(Husband)
Full Name_____

(Wife)
Full Name_____

Street Address_____

City_____ State_____ Zip_____

(Husband)
Birth Date _____

(Wife)
Birth Date _____

U. S. Citizen? ☐ Yes ☐ No

U. S. Citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

B. MEDICAL DATA

Name of Ill Spouse_____

Diagnosis _____

Prognosis _____

Course of Treatment _____

Residence of Ill Spouse ☐ Home ☐ Nursing Home ☐ Assisted Living Facility

Name of Well Spouse _____

Health of Well Spouse _____

Residence of Well Spouse ☐ Home ☐ Nursing Home ☐ Assisted Living Facility

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the first date entered on a continuous basis _____

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$_____	$_____
Retirement Benefits (Gross)	$_____	$_____
VA Disability Benefit	$_____	$_____
Annuity Income	$_____	$_____
Rental Income	$_____	$_____
Total Monthly Income	$_____	$_____

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.

D. MONTHLY COST OF CARE

$_____ Monthly Facility Cost

$_____ Monthly Incidental Cost

$_____ Monthly Prescription Cost

$_____ Monthly Other Cost

$_____ **Total Monthly Costs**

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

E. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12, and quarterly expenses by 3.)

$_____	Rent/Mortgage
$_____	Real Estate Taxes
$_____	Water
$_____	Sewer
$_____	Utilities (Heat, Electric) (1/12 of last 12 months)
$_____	Homeowner's insurance premium
$_____	Condominium fees
$_____	**Total Monthly Housing Expenses**

F. MONTHLY NON-SHELTER EXPENSES

(Please estimate)

$_____	Food
$_____	Medical
$_____	Clothing
$_____	Telephone
$_____	Transportation (including auto insurance)
$_____	Home Maintenance
$_____	Life Insurance Premiums
$_____	Health Insurance Premiums
$_____	Medicare Supplemental Insurance Premiums
$_____	Cable TV
$_____	Federal and State Income Taxes
$_____	Other
$_____	**Total Monthly Non-Shelter Living Expenses**

G. ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Husband	Wife	Joint	Liabilities
AUTOMOBILE				
ADDITIONAL AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICIATES OF DEPOSIT				
RESIDENCE				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
IRA				
OTHER REAL ESTATE				
CARE FACILITY DEPOSIT				
OTHER				
OTHER				
TOTALS				

Total countable resources as of the first continuous period of institutionalization: $_____

H. LIFE INSURANCE

COMPANY NAME (include address and policy No.)	**TYPE**	**DEATH BENEFIT VALUE**	**FACE VALUE**	**CASH VALUE**	**INSURED**	**OWNER**	**BENEFICIARY**

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 your insurance agent, or call the insurance company directly.

I. GIFTS

Please list gifts made in excess of $100.00 in any one month, to an individual or group of 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 _____
_____

J. CHILDREN (if applicable)

CHILD'S NAME	ADDRESS (With Zip Code)	TELEPHONE NUMBER	DATE OF BIRTH

Are all of your children in good health? ☐ Yes ☐ No

Are any of your children receiving SSI or other forms of government entitlement? ☐ Yes ☐ No

Do any of your children live with you in your home? ☐ Yes ☐ No

K. CERTIFICATION

The undersigned hereby represents to McKinley Law Group that the information contained in this intake form is accurate and complete, and that the undersigned understands that McKinley Law Group will rely on this information for purposes of developing a Medicaid Asset Protection 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:

_____

Once completed, please return this form to:

McKinley Law Group, LLC

160 E. Main St.| Georgetown, KY 40324
Phone: (859) 298-2150 | Facsimile: (866)823-0490

Or make an appointment request online at www.mlgky.legal