The Law Office of
Marie S. Conforti
Serving the Florida Treasure Coast

MEDICAID PLANNING FORM

Date:_____

1. GENERAL INFORMATION

Medicaid Applicant:

Medicaid Applicant's Full Name:_____

Home Address (or nursing home): Street _____

City:_____ State: _____ Zip: _____

Applicant Date of Birth:_____ Applicant Soc. Sec. #:_____

If in nursing home, name & date admitted :_____

Phone with area code:_____

Spouse:

Is Spouse Deceased? □ Yes □ No *If yes,* date of death:_____

If no: Spouse Full Name:_____

Street: Address: _____ City:_____ State: _____ Zip: _____

Spouse Date of Birth:_____ Spouse Social Security #: _____

Home Phone with area code:_____

E-Mail:_____ Fax:_____

***Children (if applicable) Provide full names, addresses, phones with area code*:**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

2. ASSET INFORMATION

Home: Do you own your own home? Yes □ No □

If yes, type of ownership: □ Applicant □ Spouse □ Applicant & Spouse Jointly □ Other

Address: _____ Approx. Value: $_____

Bank Accounts: *List all types of bank accounts held during the last 36 months:*

1. Bank _____ Account # _____

Type of Ownership: Applicant □ Spouse □ Applicant & Spouse Jointly □ Other □

Approx. Balance $_____ If Closed, date closed _____

2. Bank _____ Account # _____
Type of Ownership: Applicant □ Spouse □ Applicant & Spouse Jointly □ Other □
Approx. Balance $_____ If Closed, date closed _____
3. Bank _____ Account # _____
Type of Ownership: Applicant □ Spouse □ Applicant & Spouse Jointly □ Other □
Approx. Balance $_____ If Closed, date closed _____
4. Bank _____ Account # _____
Type of Ownership: Applicant □ Spouse □ Applicant & Spouse Jointly □ Other □
Approx. Balance $_____ If Closed, date closed _____

Life Insurance:

1.Company _____Policy # _____ Owner: _____

Face Value: $_____ Cash Surrender Value: $_____

2.Company _____Policy # _____ Owner: _____

Face Value: $_____ Cash Surrender Value: $_____

3.Company _____Policy # _____ Owner: _____

Face Value: $_____ Cash Surrender Value: $_____

Any Other Assets Not Mentioned Above?_____

Transfers: Have you transferred any property within the last 36 months? □Yes □ No *If yes:*

1. Type of Property: _____
To whom transferred _____ Approx Value: $_____
2. Type of Property: _____
To whom transferred _____ Approx Value: $_____
3. Type of Property: _____
To whom transferred _____ Approx Value: $_____

Monthly Income:	Applicant	Spouse
Social Security/Month	$_____	$_____
Pension/Month	$_____	$_____
Veteran Benefits/Month	$_____	$_____
Other Income/Month	$_____	$_____

Veteran Status:

Is applicant a veteran? □Yes □No

Is spouse a veteran? □Yes □No

3. ADDITIONAL APPLICANT INFORMATION:

Has prepaid funeral? □Yes □No

If yes, name of funeral director _____

Has burial plot? □Yes □No

Owns automobile? □Yes □No

Has safe deposit box? □Yes □No

Has power of attorney? □Yes □No

If yes, held by _____

Has health care proxy? □Yes □No

Has living will? □Yes □No

Is expecting an inheritance? □Yes □No

Has Medicare? □Yes □No

If yes: Has Medicare Part A? □Yes □No

Has Medicare Part B? □Yes □No

Medicare ID# _____

Has private health insurance? □Yes □No

If yes, name of company_____

Policy # _____ Monthly Premium $_____