THE MEDICAID FIRM

CLIENT QUESTIONNAIRE

Date:

Client

Full Name:		
Date of Birth:	Social Security #:	
Primary Residence Address:		
City:	State:	Zip:
Home Phone:	Mobile:	
Email address:		
Date of Marriage:		
Are you a Veteran? ☐ yes ☐ no		
Citizenship:		
Employer/Business Name:		
Position:		
Self Employed?		
Business Address:		
Business Telephone:		

Spouse

Full Name:	
Date of Birth:	Social Security #:
Mobile:	
Email address:	
Veteran? ☐ yes ☐ no	
Citizenship:	
Employer/Business Name:	
Position:	
Self Employed?	
Business Address:	
Business Telephone:	

Children - Please list in birth order
Child #1

Name:		
Whose Child: ☐ Husband ☐ Wife ☐ Both		
Address (if different):		
City:	State:	Zip:
Telephone:		
Date of Birth:		
Spouse Name:		
Child:	Date of Birth:	
Child:	Date of Birth:	
Child:	Date of Birth:	

Child #2

Name:		
Whose Child: ☐ Husband ☐ Wife ☐ Both		
Address (if different)):		
City:	State:	Zip:
Telephone:		
Date of Birth:		
Spouse Name:		
Child:	Date of Birth:	
Child:	Date of Birth:	
Child:	Date of Birth:	

Child #3

Name:		
Whose Child: ☐ Husband ☐ Wife ☐ Both		
Address (if different)):		
City:	State:	Zip:
Telephone:		
Date of Birth:		
Spouse Name:		
Child:	Date of Birth:	
Child:	Date of Birth:	
Child:	Date of Birth:	

Income Sources

	Client	*Spouse/Partner*
Employment		
Social Security		
Social Security Disability		
Pension		
IRA Distribution		
Annuity Distribution		
Rental Property Income		
Crops/Farmland Income		
Business Income		
Dividends		
Other		

Financial Banking Institutions - Checking and Savings accounts, Money Market accounts, CDs, Investment accounts, Stocks, Retirement accounts, etc.

Name of Institution	*Type of Account*	*Names on Account*	*Balance/Value*

Real Property

1) Address:
Value:
Owner:
2) Address:
Value:
Owner:
3) Address:
Value:
Owner:

Vehicles/Boats/Farm Equipment

Make	*Model*	*Year*	*Value*

Life Insurance

Name of Provider	*Beneficiary*	*Face Value*	*Cash Value*

Long Term Care Insurance

Name of Provider	*Account Number*	*Year of Policy*

Health Care

Do you have any of the following?

Medicare Part A:	☐ yes	☐ no
Medicare Part B:	☐ yes	☐ no
Medicare Supplement:	☐ yes	☐ no
Other Insurance:	☐ yes	☐ no
Premium Payment (monthly, quarterly, yearly):		

Financial Power of Attorney (FPOA)

Who would you like to name as your agents for purposes of making financial decisions?

1.
2.
3.

Durable Power of Attorney for Health Care (DPOAHC)

Who would you like to name as your agents to assist with health care decisions?

1.
2.
3.