ELDER LAW of LOUISVILLE

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CONFIDENTIAL COMPREHENSIVE CLIENT INTAKE ASSESSMENT

DATE COMPLETED: ______________ NAME OF STAFF PERSON: ________________

LOCATION OF INTERVIEW: ______________ CLIENT: ______________________________

****

PERSON(S) SUPPLYING ANSWERS TO THESE QUESTIONS:

Name: ______________________________

If not client, relationship to Elder(s): __________________________

Address: __________________________

____

Home Telephone: (______) ________-__________ Work Telephone: (______) ________-__________

Cell phone: (______) ________-__________ Email: ________________@ _______. ______

Long-Term Care person present at interview? Y_______ N _______ N/A _______

Community spouse, if any, present at interview? Y_______ N _______ N/A _______

Other persons present at interview:

Name	Address	Telephone #	Date of Birth
____________	________________________	(______) _______-________	_____/_____/_____
____________	________________________	(______) _______-________	_____/_____/_____
____________	________________________	(______) _______-________	_____/_____/_____

****

Primary Concerns (please circle those that apply or add own concerns):

Personal Safety:	at home	driving	climbing stairs	walking	out in public
Personal Health:	hearing	vision	balance	memory	mobility
	dexterity	hygiene	dietary concerns	agility	concentration
	forgetfulness	sleeping	comprehension	eating	medication

Other concerns: ____

____

Financial Information:

Gross Assets: HUSBAND WIFE

$__________________ $__________________

Other financial concerns: ____

SECTION 1 GENERAL INFORMATION

A. PERSONAL INFORMATION

	Husband	Wife
Full Name:	______________________________	______________________________
Other or Former Names:	______________________________	______________________________
U.S. Citizen:	Yes_______ No ________	Yes_______ No ________
If not citizen, legal Alien's date of entry to U.S.	_____/______/______	_____/______/______
Date of Birth:	_____/______/______	_____/______/______
Place of Birth:	_______________________	_______________________
Soc. Sec. #:	_______-_______-_______	_______-_______-_______

Date and Place of Marriage: ____

	Husband	Wife
Previously married?	Yes_______ No ________	Yes_______ No ________
	Number of Previous Marriages: _________	Number of Previous Marriages:_________
	Date and Place of Previous Marriage:	Pre- or Post-Nuptial Agreement? Y______ N______

HUSBAND	WIFE
____	____
____	____
____	____

	Husband	Wife
If yes, prior marriage end: (Circle One)	Death / Divorce	Death / Divorce

If widowed:

Name: ____________________________ Date of Death: _____/______/______

Social Security Number: _______-_______-_______ Date of Birth: _____/______/______

Domicile at death: ____

If divorced:

Ex-spouse's Name: ____________________________ Date of Divorce: _____/______/______

Court of Jurisdiction: ____

	Husband	Wife
Veteran:	Y______ N______	Y______ N______
If yes, branch of service:	_________________	_________________

Date of service:

Husband From	Husband To	Wife From	Wife To
____/____/____	____/____/____	____/____/____	____/____/____

B. HOME INFORMATION

Address: ______________________ ______________________

______________________ ______________________

Home Tel.: (_____) _______-__________ (_____) _______-__________

Work Tel.: (_____) _______-__________ (_____) _______-__________

Cell Tel.: (_____) _______-__________ (_____) _______-__________

Fax: (_____) _______-__________ (_____) _______-__________

Email: ______________________@__________________. ________

C. KEY FAMILY INFORMATION

Contact information for children of this marriage:

Name	Address	Telephone #	Date of Birth
__________	______________________	(_____) _______-_______	____/____/____
__________	______________________	(_____) _______-_______	____/____/____
__________	______________________	(_____) _______-_______	____/____/____
__________	______________________	(_____) _______-_______	____/____/____
__________	______________________	(_____) _______-_______	____/____/____

Contact information for children from Husband's prior marriage(s):

Name	Address	Telephone #	Date of Birth
__________	______________________	(_____) _______-_______	____/____/____
__________	______________________	(_____) _______-_______	____/____/____

Contact information for children from Wife's prior marriage(s):

Name	Address	Telephone #	Date of Birth
__________	______________________	(_____) _______-_______	____/____/____
__________	______________________	(_____) _______-_______	____/____/____

Contact information for children who are disabled:

Name	Address	Telephone #	Date of Birth
__________	______________________	(_____) _______-_______	____/____/____
__________	______________________	(_____) _______-_______	____/____/____

SECTION 2 ASSET INFORMATION

1. PERSONAL RESIDENCE

Owned: Y______ N______ Rented: Y______ N______ If so, is there as lease? Y______ N______

If residence is rented, nature of rental: Single-Family house ______ Apartment______ Condo______

Residential Care ______ Life Care ______ Senior Housing ______ Subsidized? Y______ N______

If residence is owned, Deed: d: _____/_____/_____ r: _____/_____/_____ V____ P____

Did you transfer/gift your residence in the last 3 years? Y____ N____ N/A _____

If you did transfer/gift your residence, did you retain a "life use?" Y____ N____ N/A _____

a) Owner(s): ____

b) Form of Ownership: Joint_____ Tenants in Common_____ Individual_____ Trust_____

c) Estimated Fair Market Value (FMV): $________________

d) Estimated amount of Mortgage: $________________

e) Type of Mortgage: First_____ Second_____ HELOC_____ RAM_____

f) When purchased: _____/_____/______

g) Estimated purchase price: $________________

h) Estimated Current Basis $________________

(increased by death of previous spouse, etc. / Basis = equals cost + improvements)

i) Single Family: Y______ N______ If no, then number of Units: ______________

j) If there a <u>child</u> that has lived in the residence for at least 2 years? Y______ N______

If so, has the child provided personal care—care that might have kept the parent(s) out of Long-Term Care (LTC)—to the parent(s)? Y______ N______

k) If other owner is a <u>sibling</u>, has that sibling lived in the residence for at least one year? Y______ N______

l) Does the sibling have an equity interest in the home? Y______ N______

m) Does the LTC spouse (or potential) have a minor or disabled child? Y______ N______

n) If in LTC, does the LTC spouse intend to return home? Y______ N______

Notes:

____

____

____

____

____

2. <u>OTHER REAL PROPERTY LOCATED OUTSIDE OF KENTUCKY</u>

Description And Location	How Title is Held*	Cost or Basis	Market Value
____________	____________	$____________	$____________
____________	____________	$____________	$____________
____________	____________	$____________	$____________
____________	____________	$____________	$____________
____________	____________	$____________	$____________

*Explanation of title: Jointly

Jointly with rights of survivorship?

Tenants in common?

In a Living Trust?

Qualified **P**ersonal **R**esidence **T**rust (QPRT)?

Inherited? $________________

(For example, if you inherited your parent's home, what was the home worth when you inherited it?)

3. BANKING/FINANCIAL ASSETS

Bank Account(s):

Financial Institution	Type of Acct.	Acct. # Title on Account	Balance

IRA(S):

Owner	Type of Acct.	Acct. # Beneficiary	Balance

CD(S):

Financial Institution	Type of Acct.	Acct. # Title on Account	Balance

Mutual Fund(s):

Broker/Agent	Type of Acct.	Acct. # Title on Account	Balance

Annuity(s):

Financial Institution	Type of Acct.	Acct. # Title on Account	Balance

Life Insurance:

Insurance Company	Owner	Policy #	Beneficiary	Life or Term	Cash Value

Long Term Care Insurance:

Insurance Company	Owner	Policy #	Beneficiary	Life or Term	Cash Value

Bonds-Savings or Other:

Bond Type	Owner	POD	Description	Bond #	Market Value

Stocks:

Name of Stock	Cert/Book	Owner	# of Shares	CUISP	Unit Value/sh.

Retirement Accounts (i.e. 401(k)'s, 403(b)'s, Profit Sharing, Retirement):

Owner	Type of Acct.	Acct. # Beneficiary	Balance

Other assets: (For example, 2nd vehicle, etc.)

Please indicate any accounts that have been closed in the last 36 months (60 months if Trust Accounts):

Financial Institutions: ______________________________

Account #: ______________________________

Owner(s): ______________________________

Amounts: ______________ Where did funds go?: ______________

Financial Institutions: ______________________________

Account #: ______________________________

Owner(s): ______________________________

Amounts: ______________ Where did funds go?: ______________

4. INCOME

a. Fixed Monthly Sources:	**Husband:**		**Wife:**
Social Security	$__________		$__________
R.R. Retirement	$__________		$__________
Pension (_______)	$__________		$__________
V.A. Pension	$__________		$__________
Wages	$__________		$__________
Other (______)	$__________		$__________
Totals:	$__________		$__________
Total of Both		$__________	

b. Non-Fixed Monthly Sources:		
Interest	$__________	$__________
Dividends	$__________	$__________
Rental (Net)	$__________	$__________

Other	$__________		$__________
Totals:	$__________		$__________
Total of Both:		$__________	

c. Annuity

Amount	$__________		$__________
Survivorship Rights	$__________		$__________
Not Deferred	$__________		$__________
Totals:	$__________		$__________
Total of Both:		$__________	

d. Distributions

Are you taking any distributions from an IRA, 401(k) or 403(b)? Y_____ N_____ N/A_____

IRA/401(k)/403(b)	$__________		$__________
IRA/401(k)/403(b)	$__________		$__________
Totals:	$__________		$__________
Total of Both:		$__________	

e. Liens

Are there any existing liens against your real property: Y_____ N_____ N/A_____

f. Debts

List all outstanding debts, including vehicle loans, credit card debt, and personal loans:

Debt:	Amount Owed:
____________________	$________________
____________________	$________________
____________________	$________________
____________________	$________________

SECTION 3 CALCULATION FOR XIX QUALIFICATION

1. CHECKLIST OF EXEMPT ASSET

	Husband	Wife
Burial Plot owned	________	________
Burial Trust	________	________
Life Insurance	________	________

Life Insurance: Y______ N______ Under $1500: Y______ N______ Owner of policy: ____________________

Automobile: Y______ N______ Number: ______ (If more than one vehicle, list most valuable)

Year: _________ Make: ________ Model: ________ Approx. Value: _________

All furnishings allowed

Other real or personal property essential for self-support, cash, etc.

a) $1,600 for LTC spouse Y______ N______

b) $3,200 for couple

2. INHERITANCES (Attach a separate sheet to document this information.)

Any expected Inheritances:	HUSBAND	WIFE
From:	____________________	____________________
From:	____________________	____________________

3. TOTAL NONEXEMPT ASSETS

Community Property (if applicable): ____

Husband's Separate Property: ____

Wife's Separate Property: ____

4. COST OF LIVING (EST.) PER MONTH

	Husband	Wife	Both
a) Housing			
If own, mortgage, taxes, etc.	________	________	________
If rent, amt. of monthly rental	________	________	________
b) Insurance			
Health	________	________	________
LTC	________	________	________
Life	________	________	________
Other (vehicle)	________	________	________
c) Health and Medications	________	________	________
d) Food	________	________	________
e) Entertainment and travel	________	________	________
f) Support for child(ren)	________	________	________
g) Other	________	________	________
TOTALS	________	________	________

*Client(s) aware of property tax deferral option? Y_______ N_______

Currently using it? Y_______ N_______

Intend to in future? Y_______ N_______

Minimum monthly needs allowance?

a) Mortgage or rent _______

b) Real Estate Taxes _______ (exclude sewer use fees if listed sep.)

c) Home Owner's Ins. _______

d) Condo Fees _______

Total: _______

Base Shelter Amount: _______

SECTION 4 MEDICAL INFORMATION

PHYSICAL/COGNITIVE CONDITIONS (Diagnoses, if any)

1. Physical Conditions:

Husband:	**Wife:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

2. Cognitive Conditions:

Husband:	**Wife:**
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

3. Medications / Taken for:

Husband:	**Wife:**
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

4. Activities of Daily Living:

	Husband	Wife
Feeds Independently	Y____ N____	Y____ N____
Bathes Independently	Y____ N____	Y____ N____
Uses Toilet Independently	Y____ N____	Y____ N____
Dresses Independently	Y____ N____	Y____ N____
Transfers Independently	Y____ N____	Y____ N____
Requires Supervision	Y____ N____	Y____ N____

5. Capacity (Initial indication only—may revise opinion upon review of other information.)

Husband	Y___ N___	Able to sign name:	Y___ N___
Wife	Y___ N___	Able to sign name:	Y___ N___

6. Primary Physicians

Husband:

Dr. ____________________________

Specialty: ______________________

Address: ______________________

____

Phone: (_____) ______-__________

Fax: (_____) ______-__________

Wife:

Dr. ____________________________

Specialty: ______________________

Address: ______________________

____

Phone: (_____) ______-__________

Fax: (_____) ______-__________

7. Specialty Physicians' Information:

Husband:

Dr. ____________________________

Specialty: ______________________

Address: ______________________

____

Wife:

Dr. ____________________________

Specialty: ______________________

Address: ______________________

____

Phone: (____) ______-__________

Fax: (____) ______-__________

Dr. ______________________________

Specialty: __________________________

Address: ____________________

____

Phone: (____) ______-__________

Fax: (____) ______-__________

Dr. ______________________________

Specialty: __________________________

Address: ____________________

____

Phone: (____) ______-__________

Fax: (____) ______-__________

Dr. ______________________________

Specialty: __________________________

Address: ____________________

____

Phone: (____) ______-__________

Fax: (____) ______-__________

Phone: (____) ______-__________

Fax: (____) ______-__________

Dr. ______________________________

Specialty: __________________________

Address: ____________________

____

Phone: (____) ______-__________

Fax: (____) ______-__________

Dr. ______________________________

Specialty: __________________________

Address: ____________________

____

Phone: (____) ______-__________

Fax: (____) ______-__________

Dr. ______________________________

Specialty: __________________________

Address: ____________________

____

Phone: (____) ______-__________

Fax: (____) ______-__________

8. Long Term Care (LTC)

Is one spouse in LTC? Y ______ N______ Husband______ or Wife______

If so, date of entry (30-day continuous stay since entry): ________________________

Name of LTC facility: ____

Address: ____

Telephone Number: (____) ______-__________

Administrator (contact person and position): ________________________________

Is it a Medicaid-certified facility? Y______ N______

What is the cost of the facility? (Use private pay rate)

Daily rate: $______________

Monthly rate: $______________

Please list all dates of institutionalization: (if continuous time in hospital or skilled nursing facility exceeds 30 days)

Married Couples only:

Husband:	FROM	TO
Name of facility: __________________	____/____/____	____/____/____
Name of facility: __________________	____/____/____	____/____/____
Name of facility: __________________	____/____/____	____/____/____
Name of facility: __________________	____/____/____	____/____/____

Wife: FROM TO

Name of facility: ____________________ ___/___/___ ___/___/___

Name of facility: ____________________ ___/___/___ ___/___/___

Name of facility: ____________________ ___/___/___ ___/___/___

Name of facility: ____________________ ___/___/___ ___/___/___

9. Hospital

Is one spouse in a hospital? Y ______ N______ Husband______ Wife______

If so, what is the date of admission? ___/___/___ ___/___/___

Reason for admission: ____________ ____________

Additional comments regarding admission: ____

____

Convalescence in LTC expected? Y_____ N_____ Y_____ N_____

If LTC placement expected, likely to return home? Y_____ N_____ Y_____ N_____

Has either spouse been admitted to the hospital in the past 2 years?

Husband: Y_____ N_____ Wife: Y_____ N_____

SECTION 5 NAMES OF OTHER PROFESSIONALS

Accountant: ____

Firm Name: ____

Address: ____

Telephone: (____) _____-_________ Fax: (____) _____-_________

Cell phone: (____) _____-_________ Email: ____________________@______.______

Tax Preparer:____

Firm Name: ____

Address: ____

Telephone: (____) _____-_________ Fax: (____) _____-_________

Cell phone: (____) _____-_________ Email: ____________________@______.______

Financial Advisor:____

Firm Name: ____

Address: ____

Telephone: (____) _____-_________ Fax: (____) _____-_________

Cell phone: (____) _____-_________ Email: ____________________@______.______

Insurance Agent:____

Firm Name: ____

Address: ____

Telephone: (____) _____-_________ Fax: (____) _____-_________

Cell phone: (____) _____-_________ Email: ____________________@______.______

Other Attorney(s):____

Firm Name: ____

Address: ____

Telephone: (____) _____-________ Fax: (____) _____-________

Cell phone: (____) _____-________ Email: _______________@_____._____

Other:____

Firm Name: ____

Address: ____

Telephone: (____) _____-________ Fax: (____) _____-________

Cell phone: (____) _____-________ Email: _______________@_____._____

SECTION 6 CAREGIVER INFORMATION

Person(s) Responsible For Care

Who now has assistance responsibilities?

For Husband: __________________________________

For Wife:__________________________________

Are there any children or family member(s) who are not available or relied upon to help with management or other needs of Husband's or Wife's care?

Y________ N________

If so, please list child or relative:

____

____

Why?

____

____

____

SECTION 7 INSURANCE INFORMATION

HEALTH INSURANCE:

Husband:

_______HMO Description: ______________________________

_______Medicare Supp. Description: ______________________________

_______Other Description: ______________________________

_______Other Description: ______________________________

Wife:

_______HMO Description: ______________________________

________Medicare Supp. Description: ______________________________________

________Other Description: ______________________________________

SECTION 8 LEGAL DOCUMENTS

Does each have the following documents:			Husband	Wife
a. **Will**			Y____ N____	Y____ N____
Does client have originals?	Y____	N____		
Does our office have copies?	Y____	N____		
b. **Trust, Revocable**			Y____ N____	Y____ N____
Does client have originals?	Y____	N____		
Does our office have copies?	Y____	N____		
c. **Durable Power of Attorney**			Y____ N____	Y____ N____
If so, Statutory Form?	Y____	N____		
Does client have originals?	Y____	N____		
Does our office have copies?	Y____	N____		
d. **Living Will/ Designation of Health Care Agent**			Y____ N____	Y____ N____
If so, Statutory Form?	Y____	N____		
Does client have originals?	Y____	N____		
Does our office have copies?	Y____	N____		
e. **Designation of Conservator**			Y____ N____	Y____ N____
If so, Statutory Form?	Y____	N____		
Does client have originals?	Y____	N____		
Does our office have copies?	Y____	N____		
f. **Real Estate Deed(s)**			Y____ N____	Y____ N____
Does our office have copies?	Y____	N____		

SECTION 9 CAPITAL GAINS / GIFTS

RESIDENCE: Capital gains

If own residence, or previously did:

a) have you ever given away part or remainder of the house (retaining a life estate)? Y______ N______

If yes, please explain:

____

____

____

b) has owner(s) ever used capital gains exclusion? Y______ N______
($250,000 for single person; $500,000 for couple)

c) has owner(s) lived in residence for 2 of the past 5 years? Y______ N______

GIFTS: Look-Back Period

Have either given gifts of $500 or more within the past 36 months? Y______ N______

If yes, attach a Schedule of Gifts including to whom the gift was given, amounts and dates of each gift.

Any gifts/transfers made from a trust or to an irrevocable trust within The last 60 months? Y______ N______

If yes, attach a Schedule of Gifts including to whom the gift was given, amount and date of each gift.

Are you the beneficiary of any irrevocable trust? Y______ N______

If yes, please explain:

____

____

Gift tax returns filed on any gifts (in excess of $10,000 per recipient)? Y______ N______

If so, indicate the nature of the gifts, amounts given and years returns were filed.

____

____

SECTION 10 GOALS OF CLIENT

Goals of Client

_____ I/We would like to be able to have the value of my home protected should I require long term medical care

_____I/We would like to be able to have my family members know what to do should I require long term medical care

_____I/We would like to know my spouse has enough to live comfortably should I pass away first

_____I/We would like to know my spouse would be able to protect cash savings should I require long term medical care

_____I/We would like to be able to have my children/ loved ones benefit from my wealth

_____I/We would like to be able to have my family members know what my wishes are

_____I/We would like to know my children/ loved ones are authorized to help when I need help

_____I/We would like to be able to avoid Probate

_____Other: ____

_____Other: ____

GENERAL COMMETNS AND OBSERVATIONS:

____

____

ACKNOWLEDGEMENT:

THE INFORMATION CONTAINED IN THIS COMPREHENSIVE MEDICAID INTAKE ASSESSMENT IS COMPLETE, CORRECT, AND TRUE TO THE BEST OF OUR KNOWLEDGE AND BELIEF.

________________________________ ________________________________

PRINT NAME SIGNATURE

DATE: ____/____/____

________________________________ ________________________________

PRINT NAME SIGNATURE

DATE: ____/____/____