STEPHANIE L. SCHNEIDER, P.A.
CLIENT MEDICAID QUALIFIED INCOME TRUST QUESTIONNAIRE

INSTRUCTIONS:

(A) PLEASE COMPLETE THE QUESTIONNAIRE COMPLETELY TO THE BEST OF YOUR ABILITY. YOU MAY CALL OUR OFFICE FOR ASSISTANCE.

(B) PLEASE BRING THE FOLLOWING DOCUMENTS WITH YOU AND WE WILL COPY THEM HERE DURING YOUR APPOINTMENT:

1. Proof of Medicaid applicant's gross social security benefit. You may call the Social Security Administration at 1-800-772-1213 to request a TPQY statement.
2. Proof of Medicaid applicant's gross pension benefit (letter from pension company).
3. Proof of other sources of Medicaid applicant's gross income (statements).

(C)YOUR ACCURACY AND COMPLETENESS IN RESPONDING WILL HELP US TO BEST ADVISE AND REPRESENT YOU. PLEASE COMPLETE ALL PARTS OF THE QUESTIONNAIRE OR WE WILL BE UNABLE TO MEET WITH YOU.

I. GENERAL INFORMATION

1. Were you referred to our office and if so, by whom? _____.
2. If not, what made you choose our office? _____.
3. What is the purpose of your visit to our office? _____.
4. Do you or your spouse have any other legal issues which our office should be aware of? ___. If yes, please explain: _____.

II. BACKGROUND AND FAMILY INFORMATION

1. Husband's Name:_____
   Husband's D.O.B.:_____ SS#_____
   Phone Number(s):(H)_____(O)_____
   Current Address:_____
   If deceased, date, county and state of death: _____.

2. Wife's Name: _____
   Wife's D.O.B.:_____ SS#_____
   Phone Number(s):(H)_____(O)_____
   Current Address:_____
   If deceased, date, county and state of death: _____.

3. Date of Marriage:_____

4. Children (please indicate whether any child is from a prior marriage). For minors, include their age:

	YOU	YOUR SPOUSE
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____
Adopted/Half-blood	_____	_____

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Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____
Adopted/Half-blood _____ _____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____
Adopted/Half-blood _____ _____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____
Adopted/Half-blood _____ _____

5. If no surviving children, list names of siblings for each spouse.

	YOU	YOUR SPOUSE
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____

6. Names of living parents:

	YOU	YOUR SPOUSE
Name\Age	_____	_____
Relationship	_____	_____
Address	_____	_____
Phone #	_____	_____

Name\Age _____ _____
Relationship _____ _____
Address _____ _____
Phone # _____ _____

III. GROSS MONTHLY INCOME

THIS MUST INCLUDE INCOME FROM ALL SOURCES, EVEN IF REINVESTED, AS WELL AS ANY DEDUCTIONS FROM SOCIAL SECURITY OR PENSIONS. IF YOU RECEIVE A PENSION, BRING THE BOTTOM OF YOUR MOST RECENT CHECK.

Social Security: (INCLUDE MEDICARE DEDUCTIONS)

YOU	SPOUSE	JOINT
$_____	$_____	

Employment:

$_____ $_____

Pensions: (INCLUDE ANY DEDUCTIONS)

$_____ $_____

From: _____ From: _____

$_____ $_____

From: _____ From: _____

IRA's:

$_____ $_____

Annuities:

$_____ $_____

Interest on Bank Accounts, Savings Accounts, C.D.'s:

$_____ $_____ $_____

Dividends on Stocks and Bonds:

$_____ $_____ $_____

Other (i.e. rent):

$_____ $_____ $_____

TOTALS:

$_____ $_____ $_____

Which sources of income have a benefit for a surviving spouse? _____

_____

IV. MONTHLY ESTIMATED BUDGET

Rent/Mortgage Payment/Facility $_____

Utilities: $_____

Car Payment/Maintenance: $_____

Clothing: $_____

Food/Personal Household: $_____

Insurance: $_____

Medical Expenses (incl Prescriptions) $_____

Taxes: $_____

Vacation/Entertainment: $_____

Emergency Fund: $_____

Other: $_____

TOTAL MONTHLY EXPENSES: $_____

V. MONTHLY LIABILITIES

Mortgages: $_____

Notes to banks: $_____

Notes to others: $_____

Unpaid medical: $_____

Charge card bills: $_____

Other: $_____

TOTAL MONTHLY LIABILITIES: $_____

VI. QUALIFIED INCOME TRUST

1. Name & address of nursing home where Medicaid applicant resides: _____

_____

2. Name & address of financial institution where Qualified Income Trust bank account will be established:

_____

3. Name & address of financial institution (including account #) where social security and pension are deposited: _____

_____

4. If Medicaid applicant is not competent, provide name and address of person assisting (i.e. legal guardian; power of attorney) _____

5. Attach copy of document that is the legal authority for the person identified in question 4 (i.e. durable power of attorney; Letters of Guardianship).

6. Name & address of trustee (person who will administer the trust): _____

_____

7. Name & address of successor trustee: _____

_____

8. Name, address and relationship of the trust's contingent beneficiary(ies): _____

_____

_____

9. Tax identification number of trust: _____

VII. HEALTH INSURANCE: PLEASE PROVIDE THE NAME AND ADDRESS OF THE COMPANY FOR THE FOLLOWING:

	HUSBAND	**WIFE**
Medicare/Private Insurance		
Company:	_____	_____
Address:	_____	_____
Medicare Supplement		
Company:	_____	_____
Address:	_____	_____
Long Term Care Insurance		
Company:	_____	_____
Address:	_____	_____
Other, Cancer, Accidental		
Company:	_____	_____
Address:	_____	_____

VIII. PERSONAL INFORMATION

1. Have you and your spouse used your over-age 55 exemption from capital gains taxes on the sale of a residence? _____

2. Have arrangements been made for the disposition of your body at death? _____ Are they paid for? _____ Please describe the arrangements and who they are with:_____ _____.

3. Are you or your spouse a veteran? ____ If yes, did you serve in wartime? ___ Do you currently receive any benefits? __ If yes, please explain:_____.

4. Are you or your spouse at risk because of a medical condition or family history of becoming seriously ill or disabled or, are you presently experiencing an illness? __ If yes please explain: _____ _____.

5. Does anyone to whom you may be leaving part of your estate require help or protection in managing money or other property? __ If yes, please explain._____.

IX. ASSETS

1. Real Estate located in Florida:

Address: _____
FMV: _____
(Indicate whether based on sale price, appraisal or tax bill)
Mortgage: _____
(Indicate name of mortgagee and balance of mortgage)
Title held by: _____
(Indicate persons and whether title is held as tenants in common, joint tenancy with rights of survivorship, tenancy by entirety)
Homestead Exemption Filed: _____

2. Real estate located outside Florida:
Address: _____
FMV: _____
(Indicate whether based on sale price, appraisal or tax bill)
Mortgage: _____
(Indicate name of mortgagee and balance of mortgage)
Title held by: _____
(Indicate persons and whether title is held as tenants in common, joint tenancy with rights of survivorship, tenancy by entirety)

3. Automobiles, Mobile Homes, Recreational Vehicles, Boats:

Type	Year	FMV	Liens	Owner

4. Stocks, securities, bonds, and investments:

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

5. Retirement and pension plans (include IRAs and 401Ks):

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
Taking minimum distribution Y-N: _____ Amount $_____ Frequency_____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
Taking minimum distribution Y-N_____Amount $_____ Frequency_____

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Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
Taking minimum distribution Y-N_____ Amount$_____ Frequency_____

6. Bank Accounts:

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

Asset: _____
Name & Address of Co. _____
Value: _____ Account #:_____
How is it titled:_____
When does it come due and interest rate: _____

7. Life Insurance:

	HUSBAND	WIFE
Name of Owner	_____	_____
Name of Insured	_____	_____
Name of Insurer	_____	_____
Policy #:	_____	_____
Face Value:	_____	
Cash Surrender Value:	_____	
Term or whole life:	_____	_____
Beneficiary (ies):	_____	

Name of Owner	_____	_____
Name of Insured	_____	_____
Name of Insurer	_____	_____
Policy #:	_____	_____

CLIENT MEDICAID QUALIFIED INCOME TRUST QUESTIONNAIRE

Face Value:_____
Cash Surrender Value:_____
Term or whole life: _____ _____
Beneficiary (ies):_____

8. Annuities:

Asset: _____ Value: _____ Account #:_____
Name & Address of Co. _____
How is it titled:_____ When does it come due and interest rate: _____
Are there survivorship benefits and who is the beneficiary:_____

Asset: _____ Value: _____ Account #:_____
Name & Address of Co. _____
How is it titled:_____ When does it come due and interest rate: _____
Are there survivorship benefits and who is the beneficiary:_____

9. Other Assets (Debts owed by others to you including description of debt, name of debtor, current unpaid balance, identify document which evidences debt):

Business interest in corporation or partnership (include name, address, percent of stock owned, book value and fair market value of stock, whether you have a Buy/Sell Agreement, Stock Option Agreement, Deferred Compensation Agreement, or other employee benefit plans) : _____
_____
_____
_____

Mortgages: _____

Promissory notes: _____

Inheritance (Are you receiving or do you expect to receive an inheritance in the near future), Powers of Appointment: _____

TOTAL OF ALL PROPERTY: $ _____

X. TRANSFERS OF ASSETS. THIS INFORMATION MUST BE COMPLETED IN FULL. IF YOU DO NOT COMPLETE THIS PORTION WE WILL NOT BE ABLE TO CONDUCT THE INTERVIEW.

1. Have you or your spouse made any gifts or transfers, of any amount, to any individuals or charities other than to a spouse within the last sixty (60) months? Yes _____ No _____ If yes, complete the following:

HUSBAND **WIFE**

Name of recipient:_____ Name of recipient:_____
Date of Gift:_____ Date of Gift:_____
Item: _____ Item: _____
Value: _____ Value: _____

Name of recipient:_____
Date of Gift:_____
Item: _____
Value: _____

Name of recipient:_____
Date of Gift:_____
Item: _____
Value: _____

Name of recipient:_____
Date of Gift:_____
Item: _____
Value: _____

Name of recipient:_____
Date of Gift:_____
Item: _____
Value: _____

Name of recipient:_____
Date of Gift:_____
Item: _____
Value: _____

Name of recipient:_____
Date of Gift:_____
Item: _____
Value: _____

XI. LEGAL DOCUMENTS

A. Last Will & Testament of Husband:

1. Name of Personal Representative:_____
Address of Personal Representative:_____
Name of Successor Personal Representative:_____
Address of Successor Personal Representative:_____

2. Name(s) of beneficiary(ies), their address and their respective share of the estate (indicate beneficiaries who are minors and at what age they are to receive part or all of their share):

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

CLIENT MEDICAID QUALIFIED INCOME TRUST QUESTIONNAIRE

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Charity Name _____
Address _____ Phone # _____

Charity Name _____
Address _____Phone # _____

3. Is there a pre or post-nuptial agreement?_____

4. If you have minor children, do you wish to name a pre-need guardian? Yes ___. I wish to name:
_____. No __

5. Do you wish to name a preneed guardian for yourself? Yes __. I wish to name: _____
_____. No ___

B. Last Will & Testament of Wife:

1. Name of Personal Representative:_____
Address of Personal Representative:_____
Name of Successor Personal Representative:_____
Address of Successor Personal Representative:_____

2. Name(s) of beneficiary(ies), their address and their respective share of the estate (indicate beneficiaries who are minors and at what age they are to receive part or all of their share):

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Name\Age_____ Relationship_____
Address _____ Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

CLIENT MEDICAID QUALIFIED INCOME TRUST QUESTIONNAIRE

Name\Age_____ Relationship_____
Address _____Phone # _____
If beneficiary predeceases you, what should happen to this beneficiary's share:_____
_____.

Charity Name _____
Address _____ Phone # _____

Charity Name _____
Address _____Phone # _____

3. Is there a pre or post-nuptial agreement?_____

4. If you have minor children, do you wish to name a pre-need guardian? Yes ___. I wish to name: _____. No __

5. Do you wish to name a preneed guardian for yourself? Yes __. I wish to name: _____ _____. No ___

C. Durable Power of Attorney for Husband: If you become incapacitated, do you want someone to handle your financial affairs and thereby avoid a guardianship?

1. Name: _____
   Address: _____
   Relationship to you: _____

2. Name: _____
   Address: _____
   Relationship to you: _____

Do you want it effective: Now? Yes ___ No ___ Only when you are incapacitated? Yes ___ No ___

D. Durable Power of Attorney for Wife: If you become incapacitated, do you want someone to handle your financial affairs and thereby avoid a guardianship?

1. Name: _____
   Address: _____
   Relationship to you: _____

2. Name: _____
   Address: _____
   Relationship to you: _____

Do you want it effective: Now? Yes ___ No ___ Only when you are incapacitated? Yes ___ No ___

E. Designation of Health Care Surrogate for Husband: If you become unconscious or unable to communicate, do you want someone to make your medical decisions and thereby avoid a guardianship?

1. Name of Primary Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

2. Name of Alternate Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

3. Name(s) of those persons, other than your surrogate, who you wish to send a copy of the executed document (i.e. your treating physician; family member):_____

F. Designation of Health Care Surrogate for Wife: If you become unconscious or unable to communicate, do you want someone to make your medical decisions and thereby avoid a guardianship?

1. Name of Primary Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

2. Name of Alternate Surrogate:_____
Address:_____
Telephone: Office _____ Home _____
Relationship: _____

3. Name(s) of those persons, other than your surrogate, who you wish to send a copy of the executed document (i.e. your treating physician; family member):_____

G. Living Will for Husband: If you are diagnosed with a terminal condition and your attending physician has determined that there can be no recovery from such condition and death is imminent do you want your life prolonged? Yes ____ No _____

1. In the event you can no longer chew food and swallow liquids orally, do you wish to receive food and water through artificial means such as a feeding tube surgically implanted in the stomach, an intravenous tube in the arm or, a nasogastric tube? Yes ____ No ____

2. Do you wish to receive medication for pain even if the amount of pain medication dulls your senses? Yes ____ No _____

3. Would you like to be cared for by Hospice. Hospice provides palliative care which includes feeding, dressing and bathing the person and administering pain medication. Hospice will not perform life sustaining measures such as CPR or restore breathing. Yes ____ No _____

4. If you also have a secondary illness (i.e. pneumonia, virus, cold) do you want the secondary illness treated (treating the secondary illness will not heal or correct the terminal illness)?
Yes ____ No _____

5. If you stopped breathing or your heart stopped beating would you want to be resuscitated?
Yes ___ No ____

6. Would you like to aid medical development in the fields of tissue and organ preservation, transplantation of tissues and tissue culture, reconstructive medicine and surgery and the development of medical research? If your body or organs are medically acceptable, upon your death do you wish to make an anatomical gift? Yes ___ No ____

If you answer "Yes" please complete the following:

a) I wish to give _____ any needed organs or parts _____only the following organs or parts:
_____
Specify the organ(s) or part(s))
_____

for the purpose of transplantation, therapy, medical research, or education;

b) _____ my body for anatomical study if needed. Limitations or special wishes, if any, are as follows:
_____

H. Living Will for Wife: If you are diagnosed with a terminal condition and your attending physician has determined that there can be no recovery from such condition and death is imminent do you want your life prolonged? Yes _____ No _____

1. In the event you can no longer chew food and swallow liquids orally, do you wish to receive food and water through artificial means such as a feeding tube surgically implanted in the stomach, an intravenous tube in the arm or, a nasogastric tube? Yes ____ No ____

2. Do you wish to receive medication for pain even if the amount of pain medication dulls your senses? Yes ____ No _____

3. Would you like to be cared for by Hospice. Hospice provides palliative care which includes feeding, dressing and bathing the person and administering pain medication. Hospice will not perform life sustaining measures such as CPR or restore breathing. Yes ____ No _____

4. If you also have a secondary illness (i.e. pneumonia, virus, cold) do you want the secondary illness treated (treating the secondary illness will not heal or correct the terminal illness)?
Yes ____ No _____

5. If you stopped breathing or your heart stopped beating would you want to be resuscitated?
Yes ___ No ____

6. Would you like to aid medical development in the fields of tissue and organ preservation, transplantation of tissues and tissue culture, reconstructive medicine and surgery and the development of medical research? If your body or organs are medically acceptable, upon your death do you wish to make an anatomical gift? Yes ___ No ____

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If you answer "Yes" please complete the following:

a) I wish to give _____ any needed organs or parts _____only the following organs or parts: _____

Specify the organ(s) or part(s))

_____

for the purpose of transplantation, therapy, medical research, or education;

b) _____ my body for anatomical study if needed. Limitations or special wishes, if any, are as follows: _____

_____

I. Living Trust for Husband (a/k/a Revocable Trust)

1. Do you want to eliminate the need to probate your estate and have your assets distributed within a short time after your passing? Yes _____ No ___

2. Name & address of Trustee or Co-Trustees: _____

_____

3. Name & address of first successor trustee: _____

_____

4. Name & address of second successor trustee: _____

_____

5. Disposition upon death of second spouse: _____

_____

_____.

6. In the event a beneficiary predeceases or fails to survive you, who should receive that person's share: _____.

7. Credit shelter trust: _____

_____.

8. Marital deduction trust: _____

_____.

J. Living Trust for Wife (a/k/a Revocable Trust)

1. Do you want to eliminate the need to probate your estate and have your assets distributed within a short time after your passing? Yes _____ No ___

2. Name & address of Trustee or Co-Trustees: _____

_____

3. Name & address of first successor trustee: _____

_____

4. Name & address of second successor trustee: _____
_____

5. Disposition upon death of second spouse: _____
_____
_____.

6. In the event a beneficiary predeceases or fails to survive you, who should receive that person's share:_____.

7. Credit shelter trust: _____
_____.

8. Marital deduction trust: _____
_____

K. ***DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS*** (Husband):

a. Would you like to designate in writing a trusted individual to make or, enforce arrangements for the disposition of your body at the time of your death? Yes ____ No _____
This individual would have authority to set the time and place of a service, communicate with a medical examiner, receive your cremains as well as take steps to enforce any anatomical gift you desire.

b. If yes, identify the primary authorized representative:
Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

c. If yes, identify the successor authorized representative:
Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

d. What is your preference for final arrangements? Burial _____ Cremation _____

e. Detail any restrictions you want to place on the representative's authority: _____
_____
_____

L. ***DECLARATION OF DESIGNEE FOR FUNERAL ARRANGEMENTS*** (Wife):

a. Would you like to designate in writing a trusted individual to make or, enforce arrangements for the disposition of your body at the time of your death? Yes ____ No _____
This individual would have authority to set the time and place of a service, communicate with a medical examiner, receive your cremains as well as take steps to enforce any anatomical gift you desire.

b. If yes, identify the primary authorized representative:
Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

c. If yes, identify the successor authorized representative:
Name:_____
Address: _____
Cell phone: _____ Work phone: _____ Home phone: _____
Relationship to you: _____

d. What is your preference for final arrangements? Burial _____ Cremation _____

e. Detail any restrictions you want to place on the representative's authority: _____
_____
_____

M. Do you have any professional advisors who you wish us to work with? Please provide us with their names, addresses and telephone number. If you are not currently working with any of the following professionals, would you like our office to provide you with a recommendation? ___ Yes ___ No

Accountant:_____

Financial Planner:_____

Insurance Advisor: _____

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____
Print Name: _____
Date: _____

_____
Print Name: _____
Date: _____

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We appreciate you completing the following questions as to yourself. Caregivers are especially conscientious about facilitating the care needs of those they care for. Unfortunately, they are often remiss when it comes to making the time to address their own. We wish to ensure that your personal legal needs are being addressed by taking the time to discuss these issues with you.

"PROPER PLANNING MAY CREATE PEACE OF MIND"

Do you have the following legal documents in place:

	YES	***NO***	***I WANT TO KNOW MORE***
A. Last Will & Testament			
B. Revocable Trust			
C. Durable Power of Attorney			
D. Springing Durable Power of Attorney			
E. Designation of Health Care Surrogate			
F. Living Will			
G. Organ Donation/Transplantation Request			
H. Declaration of Pre-need Guardian for a Minor			
I. Special Needs Trust for a disabled spouse or Family member			
J. Do Not Resuscitate Order			

If you consult with us as to your personal estate planning needs within the next three (3) months you will receive a 15% discount on the consultation and on the charge for estate planning documents. Please save a copy of this page and bring it with you to your personal consultation. We look forward to serving you.