WEAVER ◆ LOVELESS
LAW

Date: _____ **Referred By:** _____
Your Name: _____
Are you seeking services on behalf of someone else? If so, please fill out client section below.
Address: _____ City: _____ State: ____ Zip: _____
Phone (Cell): _____ Home: _____ Relationship to Client: _____
E-mail: _____ Date of Birth: _____

Client: _____ **Spouse:** _____
Address: _____ City: _____ State ____ Zip _____
Phone (Cell): _____ Home: _____ Phone (Cell): _____ Home: _____
E-mail: _____ E-mail: _____
Date of Birth: _____ Date of Birth: _____
Age: _____ Age: _____
Social Security Number: _____ Social Security Number: _____
United States Citizen? ☐ Yes ☐ No _____ United States Citizen? ☐ Yes ☐ No _____
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married
Veteran: *Client* ☐ *Spouse*☐ Are you receiving benefits? If so, amount/type: _____
If residing in a facility, facility name: _____

HEALTH STATUS
Medical condition/illnesses: _____
Can potential Medicaid applicant do the following activities?

1. Walk or stand ☐ Yes ☐ No
2. Feed himself/herself ☐ Yes ☐ No
3. Clothe himself/herself ☐ Yes ☐ No
4. Bathe himself/herself ☐ Yes ☐ No
5. Do toiletry/incontinent☐ Yes ☐ No
6. Able to sign name ☐ Yes ☐ No
7. Able to speak ☐ Yes ☐ No
8. Recognizes family ☐ Yes ☐ No
9. Homebound ☐ Yes ☐ No
10. Partially paralyzed ☐ Yes ☐ No

Is the applicant been diagnosed with dementia, memory loss or Alzheimer's? ☐ Yes; date: ____ ☐ No

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LIST ALL CHILDREN (names, addresses & phone, cell/home/work, Spouse's children if different, and if deceased):

Client	***Spouse***
a. _____	a. _____
b. _____	b. _____
c. _____	c. _____
d. _____	d. _____
e. _____	e. _____

Are all children in good health? ☐ Yes ☐ No, who?: _____
Are any children receiving SSI or other government entitlements? ☐ Yes: _____ ☐ No
Do any of your children live with you at home? ☐ Yes: _____ ☐ No
Family dynamics: _____

PEOPLE IN THE HOME

Name: _____
Address: _____
Phone (Cell): _____ Home: _____
E-mail: _____
Date of Birth: _____
Age: _____
Social Security Number: _____
United States Citizen? ☐ Yes ☐ No _____
Employment Status? _____

Name: _____
City: _____ State ____ Zip_____
Phone (Cell): _____ Home: _____
E-mail: _____
Date of Birth: _____
Age: _____
Social Security Number: _____
United States Citizen? ☐ Yes ☐ No _____
Employment Status? _____

PREVIOUS ESTATE PLANNING DOCUMENTS

Client
☐ Will ☐ Revocable Trust ☐ Living Will
☐ Financial DPOA ☐ Medical POA

Spouse
☐ Will ☐ Revocable Trust ☐ Living Will
☐ Financial DPOA ☐ Medical POA

Who prepared these documents? _____

HEALTH INSURANCE

☐ Health Insurance: _____ ☐ Prescription Plan: _____
☐ Long-Term Care Insurance: _____
☐ Supplemental Health Insurance: _____
☐ Medicare: _____ Parts: ☐ A ☐ B ☐ C ☐ D ☐ D pd. out of Soc. Sec?
☐ Medicaid: _____
☐ Dental/Vision Insurance: _____
Premiums being paid? ☐ Yes; by whom? _____ ☐ No

INCOME

INCOME	SOURCE	CLIENT	SPOUSE	JOINT	TRUST
Social Security		**$**	**$**	**$**	**$**
Interest/Dividends		**$**	**$**	**$**	**$**
VA Benefits		**$**	**$**	**$**	**$**
Pension Payments		**$**	**$**	**$**	**$**
Railroad Retirement		**$**	**$**	**$**	**$**
Retirement Income Retirement Income		**$**	**$**	**$**	**$**
TOTAL		**$**	**$**	**$**	**$**

□Applied for all available income? _____ ☐ Earnings/Wages? Retired? _____
□SSI/SSDI? _____ ☐ Unemployment _____ □Alimony? _____ ☐ Rent _____

NON-COUNTABLE INCOME-

☐ Food Stamps ☐ Income tax refunds ☐ Need Based Assistance- State/Local _____
☐ QIT/ Miller Trust ☐ Personal Needs Allowance ☐ In Kind Income- food/shelter non-countable.

RESOURCES

ASSET	NAME OF INSTITUTION	CLIENT	SPOUSE	JOINT	TRUST
Checking Account		$	$	$	$
Checking Account		$	$	$	$
Savings Account		$	$	$	$
Savings Account		$	$	$	$
Money Market		$	$	$	$
Stocks/Bonds/Savings Bonds		$	$	$	$
Mutual Fund		$	$	$	$
CDs		$	$	$	$
Annuity		$	$	$	$
Trusts/Safe Deposit Box		$	$	$	$
Homestead (Mobile Home)		$	$	$	$
Other Real Estate		$	$	$	$
Other Real Estate		$	$	$	$
Life Insurance > $1,500		$	$	$	$
Life Insurance > $1,500		$	$	$	$
Transfers		$	$	$	$
2nd Automobile, Boat, Trailer, or RV		$	$	$	$
TOTAL (2000/3000)		$	$	$	$

HOUSEHOLD EXPENSES-

☐ Mortgage/rent _____ ☐ Utilities _____
☐ HOA fee _____ ☐ Homeowners insurance _____
☐ Monthly nursing home rate _____ ☐ Property taxes _____
☐ Cell phone _____ ☐ Cable provider _____

NON-COUNTABLE RESOURCES-

☐ Homestead ☐ 1st Automobile: _____ ☐ Personal Property (not collectibles) _____
☐ Burial plots/spaces for immediate family ☐ Burial funds up to $1,500 in earmarked savings
☐ Irrevocable pre-need funeral arrangement
☐ Life insurance if no cash surrender value or if not > $1,500
☐ Resources not available (jointly owned)
☐ Pooled trust ☐ Payback Trust ☐ Third Party SNT ☐ PSK

LIABILITIES (debts and debts owed to you or your spouse)

DEBT	NAME OF INSTITUTION	CLIENT	SPOUSE	JOINT	TRUST
Credit Card		$	$	$	$
Credit Card		$	$	$	$
Credit Card		$	$	$	$
Medical Bill		$	$	$	$
Medical Bill		$	$	$	$
Medical Bill		$	$	$	$
Nursing Home Bill		$	$	$	$
Other:		$	$	$	$
Other:		$	$	$	$
Annuity		$	$	$	$
TOTAL		$	$	$	$

GIFTS/TRANSFERS (transferee, asset, date, value, why)

Client

a. _____

_____

_____

b. _____

_____

_____

Spouse

a. _____

_____

_____

b. _____

_____

_____

SELECT SERVICES (Check all that apply):

Client

☐ Med App ☐ Preplanning ☐ Asset Protection
☐ Probate ☐ Estate Planning ☐ Real Estate

Spouse

☐ Med App ☐ Preplanning ☐ Asset Protection
☐ Probate ☐ Estate Planning ☐ Real Estate

CONSULTATION NOTES. (FINANCIAL PLANNER:_____/ CPA: _____)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Capacity & Health:
Medicare Days/Admission Date:
Medicaid Recovery/Elective Share:
Goals:
Needs:
Referrals:
Alternatives:
Funding:
Primary Caregiver:
Primary Physician:

Estimated Charges $ _____ Next Appointment Date: _____

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