



TALIS LAW PLLC

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### CLIENT MEDICAID INFORMATION WORKSHEET

<b>A. PERSONAL</b>	<b>Applicant</b>	<b>Spouse</b>
1. Full Name	_____	_____
2. Addresses	_____	_____
	_____	_____
	_____	_____
3. Telephone	_____	_____
4. Email	_____	_____
5. Birthdate	_____	_____

**B. INCOME** (Pension, Social Security, SSI, wages, etc.)

1. Applicant		
	Description	Monthly amount
	_____	_____
	_____	_____
	_____	_____
	_____	_____
2. Spouse		
	Description	Monthly amount
	_____	_____
	_____	_____
	_____	_____
	_____	_____

**C. VALUE OF ASSETS**

3. Home

- a. Market value \_\_\_\_\_
- b. Mortgage \_\_\_\_\_
- c. Line of credit \_\_\_\_\_
- d. Reverse mortgage \_\_\_\_\_

4. Vehicles

Make, model, year	Loan amount	Blue book value
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Life Insurance

Type (whole life, term, etc.)	Face value	Cash value (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Long Term Care Insurance

Name of Insured	Date of Policy	Is this a Long-Term Care Policy (if know)?
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Bank Accounts (checking, savings, CD, etc.)

Type of account	Balance	Name of bank
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Retirement Accounts (IRA, Roth IRA, 401(k), etc.)

Type	Name on account	Balance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Prepaid Burial Plan

Funeral home or organization	Value
_____	_____
_____	_____

10. Other Investment Accounts (stock accounts, annuities, money market, etc.)

Type	Company	Balance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Other Real Estate

Description	Market Value	Mortgage, etc.
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. Assets Relating to Operating a Business (equipment, tools, etc.)

Description	Market Value
_____	_____
_____	_____
_____	_____
_____	_____

13. Other Assets

Description	Market Value
_____	_____
_____	_____
_____	_____

14. Do you own any real or personal property as joint tenants with any third parties?  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

**D. MEDICAL EXPENSE**

1. Non-Medicare (not Medicaid) Health insurance Expenses

Description	Cost per month
_____	_____
_____	_____
_____	_____

2. Outstanding Medical Bills

Description	Amount
_____	_____
_____	_____
_____	_____

**E. TRUSTS**

1. Does any member of your family receive income from any trust? \_\_\_\_\_  
If yes, who created the trust? \_\_\_\_\_
2. Have you ever created a trust? \_\_\_\_\_  
If yes, give details. \_\_\_\_\_
3. Do you expect to be named a beneficiary of a trust? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

**F. GIFTS AND TRANSFERS**

Have you made any gifts or transferred any assets for less than full market value to someone other than your spouse in the last five years? If yes, please describe the gift or transfer.

If the gift or transfer was to one of the following people, please note that in the description: a disabled or blind child, a child who has lived in your home for two years to care for you, or a child who was under twenty-one at the time of the gift.

Description	Date	Value of gift
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____