Arizona Medicaid Planning Services, LLC

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Information For Planning For Arizona Long Term Care System

Please complete this form prior to your appointment with our office so that we have the necessary, up-to-date, and most accurate information in order to properly advise you at the time of your initial consult.

Applicant Information (person who is at risk of long term care)**:**

Name of Applicant: _____

Age: _____ Date of Birth: _____ SSN: _____

Permanent Address: _____ Home Phone: _____

_____ Work Phone: _____

Present Location: _____ Phone: _____

Facility Address: _____ Type of Facility: _____

_____ Date Entered Facility: _____

Medicare Days Used, If Nursing Home: _____

Paid For Placement Through What Date: _____

Date of Marriage: _____ Place of Marriage: _____

U.S. Citizen: Yes❑ No❑ Place of Birth: _____

Veteran: Yes❑ No❑ | Wartime Service: Yes❑ No❑ | Attending interview: Yes❑ No❑

PREVIOUS MARRIAGES:

Name	Date of Divorce	Date of Death	Veteran?
_____	_____	_____	Yes❑ No❑
_____	_____	_____	Yes❑ No❑
_____	_____	_____	Yes❑ No❑

Spouse Information (if applicable)**:**

Name of Applicant's spouse: _____

Age: _____ Date of Birth: _____ SSN: _____

Permanent Address: _____ Home Phone: _____

_____ Work Phone: _____

Present Location: _____ Phone: _____

_____ Occupation:_____

U.S. Citizen: Yes❑ No❑ Place of Birth:_____

Veteran: Yes❑ No❑ | Wartime Service: Yes❑ No❑ | Attending interview: Yes❑ No❑

Spouse (continued):

PREVIOUS MARRIAGES:

Name	Date of Divorce	Date of Death	Veteran?
_____	_____	_____	Yes❑ No❑
_____	_____	_____	Yes❑ No❑
_____	_____	_____	Yes❑ No❑

1. **Children of This Marriage:**

a. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Work Phone:_____
E-Mail: _____ Cell Phone: _____
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

b. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Work Phone:_____
E-Mail: _____ Cell Phone: _____
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

c. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Work Phone:_____
E-Mail: _____ Cell Phone: _____
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

d. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Work Phone:_____
E-Mail: _____ Cell Phone: _____
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

e. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Work Phone:_____
E-Mail: _____ Cell Phone: _____
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

f. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Work Phone:_____
E-Mail: _____ Cell Phone: _____
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

2. **Children of Former Marriage(s):**

Does the applicant or the applicant's spouse have any children from a former marriage?

Yes❑ No❑

If yes, please complete:

a. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Child of: Applicant❑ Spouse❑
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

b. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Child of: Applicant❑ Spouse❑
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

c. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Child of: Applicant❑ Spouse❑
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

d. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Child of: Applicant❑ Spouse❑
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

e. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Child of: Applicant❑ Spouse❑
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

f. Name: _____ Date of Birth:_____
Address: _____ Home Phone: _____
_____ Child of: Applicant❑ Spouse❑
Married: Yes❑ No❑ Attending Interview: Yes❑ No❑

3. **Deceased Children:**

If any children are deceased, please complete:

a. Name: _____ Child of: Applicant❑ Spouse❑
b. Name: _____ Child of: Applicant❑ Spouse❑
c. Name: _____ Child of: Applicant❑ Spouse❑
d. Name: _____ Child of: Applicant❑ Spouse❑

4. **Disabled Children:**

If you have any disabled children, please complete:

a. Name: _____ Type of Disability: _____
Has S.S. Disability Determination Been Made: Yes❑ No❑

b. Name: _____ Type of Disability: _____
Has S.S. Disability Determination Been Made: Yes❑ No❑

c. Name: _____ Type of Disability: _____
Has S.S. Disability Determination Been Made: Yes❑ No❑

5. **Grandchildren:**

If there are any grandchildren, please complete:

Name of Grandchild	Age	Name of Parent

6. **Living Brothers and Sisters:**

Applicant	Spouse

7. **Legal Documents:**

Applicant	Is There A…	Spouse
Yes❑ No❑	**Trust or Trusts**	Yes❑ No❑
Yes❑ No❑	**Will**	Yes❑ No❑
Yes❑ No❑	**Financial Power Of Attorney**	Yes❑ No❑
Yes❑ No❑	**Medical Power Of Attorney**	Yes❑ No❑
Yes❑ No❑	**Living Will**	Yes❑ No❑
Yes❑ No❑	**Pre-Hospital Medical Care Directive**	Yes❑ No❑

8. **Medical Planning:**

a. Does it appear that the applicant may need long term care in the near future?

Yes❑ No❑

b. Describe the medical condition necessitating long term care: _____

_____

_____

c. Describe the medical treatments being administered, as well as the overall health of applicant in general terms: _____

_____

_____

_____

d. Please circle the number that describes the Applicant's ability to do the following activities (1 - needing no assistance, 3 – needs prompting, 5 - needs total assist):

I. Ambulate.....	1	2	3	4	5
II. Transfer	1	2	3	4	5
III. Toilet.....	1	2	3	4	5
IV. Eat and prepare food	1	2	3	4	5
V. Groom.....	1	2	3	4	5
VI. Bathe	1	2	3	4	5
VII. Dress	1	2	3	4	5

e. Does the applicant appear to be mentally incapacitated? Yes❑ No❑

I. If so, describe the indications:_____

_____

f. Does the applicant wander, or is he/she aggressive in any way? _____

_____

g. Describe physical and mental health and mental capacity of the applicant's spouse:

_____

_____

h. Is the applicant's spouse at risk of needing long term care? Yes❑ No❑

I. If so, describe the indications:_____

_____

i. Health Insurance:

Applicant	**Do you have …**	**Spouse**
Yes❑ No❑	**Medicare Coverage (Part A)**	Yes❑ No❑
Yes❑ No❑	**Medicare Coverage (Part B)**	Yes❑ No❑
Yes❑ No❑	**Supplemental Insurance**	Yes❑ No❑
Yes❑ No❑	**Long Term Health Care Ins.**	Yes❑ No❑
Yes❑ No❑	**Other Insurance**	Yes❑ No❑
(Please Bring Copies Of All Policies To Interview)		

9. **Monthly Income:**

Type	Applicant		Spouse		Combined
a. Monthly Paycheck (**Gross**)	_____	+	_____	=	_____
b. Monthly Paycheck (Net)	_____	+	_____	=	_____
c. Rental Income	_____	+	_____	=	_____
d. Pension And Retirement (**Gross**)	_____	+	_____	=	_____
e. Pension And Retirement (Net)	_____	+	_____	=	_____
f. Social Security Income (**Gross**)	_____	+	_____	=	_____
g. Social Security Income (Net)	_____	+	_____	=	_____
h. Dividends And Interest Income Including Reinvested Dividends And Bank Account Interest	_____	+	_____	=	_____
i. Disability And Unemployment Pay	_____	+	_____	=	_____
j. IRA Distributions (If Income)	_____	+	_____	=	_____
k. Trust Funds	_____	+	_____	=	_____
l. Annuity	_____	+	_____	=	_____
m. Note/Deed Of Trust Income	_____	+	_____	=	_____
n. Other	_____	+	_____	=	_____
TOTAL MONTHLY INCOME:	_____	+	_____	=	_____

***NOTE*: IF POSSIBLE, PLEASE BRING WRITTEN DOCUMENTATION OF CURRENT INCOME TO INTERVIEW.**

10. **Resources:**

a. Real Property:

Address	Names on Deed/Type of Ownership	Value
1.		**$**
2.		**$**
3.		**$**
4.		**$**

Tax Assessed Value	Mortgage Value	Purchase Price
1. $	**$**	**$**
2. $	**$**	**$**
3. $	**$**	**$**
4. $	**$**	**$**
***NOTE*: PLEASE BRING DEEDS OR COPIES OF DEEDS.**		

b. Vehicles (including automobiles, mobile homes and boats):

Description	Names on Title	Value	Balance on Loan
		$	**$**
		$	**$**
		$	**$**
		$	**$**

Resources: (Continued)

c. Burial Plots, Funds, or Plans:

I. Does the Applicant own a burial plot, fund, or plan? Yes❑ No❑

If yes, please complete:
Name of Company: _____ Beneficiary:_____
Current Value: _____ Balance Owed: _____
The plot/fund/plan is: Revocable ❑ Irrevocable ❑

II. Does the Spouse own a burial plot, fund, or plan? Yes❑ No❑

If yes, please complete:
Name of Company: _____ Beneficiary:_____
Current Value: _____ Balance Owed: _____
The plot/fund/plan is: Revocable ❑ Irrevocable ❑

III. Does a member of the immediate family own a burial plot, fund, or plan? Yes❑ No❑

If yes, please complete:
Name of Company: _____ Beneficiary:_____
Current Value: _____ Balance Owed: _____
The plot/fund/plan is: Revocable ❑ Irrevocable ❑

***NOTE*: PLEASE BRING A COPY/COPIES OF THE POLICY/POLICIES WITH YOU.**

d. Life Insurance:

Company	Owner	Insured Person	Beneficiary	Death Benefit	Cash Value

Resources: (Continued)

e. IRA's, 401(K)'S, Keogh, or other Retirement Plans:

Company	Owner	Type Of Account	Beneficiary	Cash Value	Current Distribution

f. Annuities:

Company	Owner	Insured Person	Beneficiary	Death Benefit	Cash Value

g. Bank Accounts and Money Market Accounts:

Bank	Type (i.e. Joint Checking, Savings, etc.)	Names On Account (Title)	Balance	Interest Rate

Resources: (Continued)

h. Certificates Of Deposit:

Bank	Name On Account	Balance	Interest Rate	Maturity Date

i. Promissory Notes or Deeds Of Trust, payable to Applicant or Spouse:

Description	Title	Value

j. Stocks and Mutual Funds:

Description	Names On Certificates	# Of Shares	Share Value	Total Value	Monthly Dividend	Purchase Price Per Share

Resources: (Continued)

k. Bonds, and Treasury Certificates if not part of a Mutual Fund:

Description	Names on Bonds	Value	Monthly Dividends	Maturity Date

l. Partnership:

Description	Ownership	Value	Maturity Date

m. Other Resources:

Description	Title	Value	Income

***NOTE*: PLEASE BRING COPIES OF ANY ANNUITY OR LIFE INSURANCE POLICY, AS WELL AS OTHER DOCUMENTS WHICH YOU FEEL MAY BE HELPFUL IN DETERMINING THE VALUE AND TITLE TO THE APPLICANT'S RESOURCES.**

11. **Transfer Of Assets:**

Has the Applicant or their spouse sold, traded, transferred any assets, or created and or funded any trusts, added or removed funds from an existing trust within the last ***sixty*** months? Please include financial gifts (>$100.00) to family members, as well as any tithing or other charitable donations.

Property Transferred	Value	Transferee	Date Transferred

12. **Outstanding Debts:**

To Whom Owed:	Amount Due:

13. **Expenses:**

a. Estimated or current monthly expenses for applicable “Out-Of-Home” or “In-Home” Care for Applicant:

Type of Expense	Monthly Amount

b. Other estimated monthly expenses, if applicable:

Type of Expense	Monthly Amount
Mortgage or Rent	$
Aps/Electric	$
Gas/Utility	$
Phone	$
Water	$
Food	$
Postage	$
Car Insurance	$
Medical and Dental Insurance Premiums	$
Prescriptions	$
Gas for Auto	$
Property Taxes	$
Home Insurance	$
Clothing	$
Entertainment	$
Life Insurance Premiums	$
Gifts/Donations	$
Newspaper/Magazines	$
Cable T.V.	$
Automobile Maintenance/Repair	$
Home Maintenance/Repair	$
Vacations	$
Unreimbursed Medical/Dental Expenses	$
Income Taxes	$
Miscellaneous (Supplies, Etc.)	$
Credit Card Debt	$
Hair	$
Other:	$
Other:	$
Other:	$
TOTAL	$

14. **Miscellaneous Questions:**

a. Does the Applicant currently have a financial advisor? Yes❑ No❑

If so, please list their name and address: _____

_____

b. Does the Applicant currently have an insurance agent for long term care insurance, or have you contacted one? Yes❑ No❑

If so, please list their name and address: _____

_____

c. Does the Applicant currently have an accountant? Yes❑ No❑

If so, please list their name and address: _____

_____

d. Does the Applicant currently have a physician? Yes❑ No❑

If so, please list physician's name and address: _____

_____

e. Is the Applicant or Spouse expecting any inheritances in the near future?

Yes❑ No❑

If so, how much to whom, and when: _____

_____

f. Is the Applicant entitled to and/or receiving benefits for long term care through the Veteran's Administration? Yes❑ No❑

If so, please describe: _____

_____

g. Does the Applicant or their spouse have any pending law suites? Yes❑ No❑

If so, please list Attrorney's name and address: _____

_____

***NOTE*: PLEASE BRING COPIES OF ANY DOCUMENTS/STATEMENTS WHICH VERIFY THE VALUE OF ALL OF THE ABOVE DESCRIBED RESOURCES HELD AT THE TIME INFORMATION IS REQUESTED FOR.**

Please be advised that Arizona Medicaid Planning Services LLC does no independent investigation into the information requested in this questionnaire. Furthermore all ALTCS planning is based on this questionnaire any omissions intentional or otherwise could result in a denial of ALTCS benefits (at no fault of Arizona Medicaid Planning Services LLC).

I hereby declare that the information listed within this document is, to the best of my knowledge, complete and accurate.

_____ _____

(Signature of person completing this document) Date