

APPLICATION INFORMATION FORM

(Please review the entire form before completing each section)

Referred By: _____ Today's Date: _____

Month of Application: _____ Scheduled Appt Date: _____

(Office Use Only) Case User ID: _____ PW: _____

Type of Services Seeking: Nursing Home Assisted Living Assistance Home Care Services

Primary Concern: Medicaid Application VA Benefits Pre-Filing Assistance Expense Planning

Individual Needing Long – Term Care

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Social Security Number ----- _____

Medicare ID _____ Email: _____

Was anyone in the armed service? Yes No; If yes, self or spouse? Self Spouse

Date Served?: _____ What Division: _____

Is your spouse deceased? Yes No Are you a US Citizen? Yes No If not Alien ID# _____

Marital Status: Married Divorced Single Widowed

Client's Address: _____

Telephone Number: _____ Email: _____

Spouse (If Applicable)

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Email: _____

Medicare ID _____ Social Security Number ----- _____

Does Your Spouse Require Long-term care as well? Yes No US Citizen? Yes No

Primary Concern: Medicaid Application VA Pre-application Assistance

Spouse's Address (If different than above): _____

Telephone: _____ Cell: _____ Email: _____

Primary Contact, Children ©, Beneficiary (b)

Primary: First Name: _____ Last Name: _____ Relationship _____

Primary Phone: _____ Cell Email: _____

Primary Address: _____

Alternate: First Name: _____ Last Name: _____ Relationship _____

Alternate Phone: _____ Cell Email: _____

Alternate Address: _____

APPLICATION INFORMATION FORM

Legal

Do You Have A Power of Attorney? Yes No Who Is Your Power: _____
 Do You Own A Trust? Yes No Who Is Your Trustee: _____

Client or Facility Address

Is the client at a facility now? Yes No Facility Name: _____ Date Admitted: _____
 Name of Contact Person at the Facility: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Client's address prior to entering facility? _____

INCOME:

Gross Monthly Income (Before Deductions)

TYPE	IF PENSION, SOURCE	IF OTHER INCOME, SOURCE	AMOUNT	OWNER

Total Amount of Applicant: _____ **Total Amount of Spouse:** _____

ASSETS:

Bank Accounts

Checking/Savings/CDs/Money Market, etc./ Safety Deposit Box

TYPE	INSTITUTION	ACCOUNT #	BALANCE/ VALUE	OWNER

Total Amount: _____

APPLICATION INFORMATION FORM

Annuities

TYPE (Income or Deferred)	CURRENT VALUE	FINANCIAL INSTITUTION	PAYMENTS/ INCOME	FREQUENCY (MTHLY, QRTLY, ANNUALLY)	OWNER

Totals:

Current Value \$ _____ Payments OR Income \$ _____

Retirement Accounts (IRAs/401k/403b/408k/SEPs)

TYPE	CURRENT VALUE	INSTITUTION	PAYMENTS/ INCOME	FREQUENCY	OWNER

Totals:

Current Value \$ _____ Payments OR Income \$ _____

Transfers/Gifts

WHAT WAS TRANSFERRED	TO WHOM	WHEN	VALUE	Recorded?	
				Yes	No

Total Value Gifted: _____

APPLICATION INFORMATION FORM

Vehicle(s)

YEAR	MAKE	MODEL	MILES	VALUE	BALANCE OWED	IS THIS A CLASSIC?	OWNER

Real Property

Homestead Property

Value	Address (If Different Living)	Mortgage Balance	Monthly Mortgage Payment	Mortgage Co.

Do any of the children live in the house? Yes No If yes, for how long? _____

Does anyone else have an equity in this property? Yes No If yes, what is your share of the equity? _____

Housing Expenses (Applicable Only If There Is A Community Spouse)

Heating and Cooling/ Electricity/Water/Waste/Taxes/ HOA fees, etc.

TYPE	PAYEE	AMOUNT	FREQUENCY

Total: _____

APPLICATION INFORMATION FORM

Additional Properties

Value	Address	Mortgage Balance	Monthly Mortgage Payment	Mortgage Co.	Rented?

Applicant or Spouse Paid Expenses For Rental Properties?

Heating and Cooling/ Electricity/Water/Waste/Taxes, etc.

TYPE	PAYEE	AMOUNT	FREQUENCY

Life Insurance Information (Do not Include Term Policies)

	Company	Policy #	Premium Paid	Owner	Face Amt	Cash Value	Loan Amount

Totals: _____

Health Insurance Information

TYPE (Supplement, Major Med, Advantage)	COMPANY	POLICY#	PREMIUM PAID	FREQUENCY	OWNER

Total Premium Paid: _____

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Additional Space or Additional Important Information
