Medicaid Personal Information Form

*** <u>All information contained in this form is confidential and protected by attorney-client privilege</u> ***

Medicaid Applicant's Name: _____ DOB: _____

Social Security No.:_____ Marital status: ☐ single ☐ married ☐ divorced ☐ widow

If married:

Spouse's Name: _____ DOB: _____

Social Security No.:_____

Where does applicant live:

Home ☐ Nursing Home ☐ Assisted Living Facility ☐ Rehab Facility ☐

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Power of Attorney or Contact Name: _____

Phone:_____ Email: _____

Address: _____

****** <u>To provide the best advice possible, you must provide the income and asset information</u> ******

Applicant's gross income (if married, provide the income for each spouse that is applicable):

Social Security: _____

Pension: _____

Annuity: _____

Rental Income: _____

Applicant's asset values (if married, provide the values for each asset owned by either spouse):

Home (value): _____

Checking account(s): _____

Saving account(s): _____

CDs, Money Market: _____

IRAs: _____

Brokerage accounts: _____

Annuities: _____

Stocks, Bonds (not held in other accounts): _____

Life Insurance (cash value): _____