

Medicaid Applicant's Survey Form

Date: _____

The Barton Law Firm, LLC

Please complete this form and bring it with you to your consultation. Do not worry if you can't answer all the questions; just provide the information you know.

Name of Medicaid Applicant: _____

Home Address or Nursing home: _____

If in nursing home, date of admission: _____

Home Tel. #: _____ Business Tel. #: _____

Soc. Sec. #: _____ Date of Birth: _____

Date of Marriage: _____ Referred By: _____

SPOUSE:

Name: _____ Date of Birth: _____

Soc. Sec. #: _____ If Deceased, Date of Death: _____

Residence Address, if different: _____

Home Tel. #, if different: _____

Names, Addresses, and Phone Numbers of Children, If Any:

Is applicant a veteran? Yes No Spouse? Yes No

■ Real Estate

Type of Ownership: (J - Joint) (H - Husband) (W - Wife) (T - Trust)

Does the applicant own his/her own home? Yes No

If yes, type of ownership: J H W T

Address and approximate value: _____

Does the applicant own any farm property? Yes No

If yes: Is the home on the farm? Yes No

 Is all of the acreage adjoining? Yes No

 Is it income producing? Yes No

Address, acreage, yearly income (if any), and approximate value: _____

Does the applicant own any other real estate? Yes No
If yes: Type of ownership: J H W

What type of property (i.e., timeshare, rental, etc.)? _____

Address, and approximate value: _____

■ Bank Accounts:

List all type of bank accounts held during the past 36 months:

Name of Bank	Account #	Type of Ownership	Approximate Balance/Date Closed
--------------	-----------	-------------------	---------------------------------

■ Life Insurance:

Name of Company	Policy	Owner	Face Value	Cash Surrender Value
-----------------	--------	-------	------------	----------------------

■ Other Assets Not Listed Above

■ Transfers

Has the applicant transferred any property within the past 36 months? Yes No

If Yes:

Type of Property	Value	Transferred To
------------------	-------	----------------

■ **Income**

	Applicant	Spouse
Social Security:	_____	_____
Pension:	_____	_____
Veteran Benefits:	_____	_____
Other:	_____	_____

■ **Other Information**

DOES THE APPLICANT....

Have a prepaid funeral? ___ Yes ___ No

 If yes, name of funeral director: _____

Have a burial plot? ___ Yes ___ No

Own an automobile? ___ Yes ___ No

Have a safe deposit box? ___ Yes ___ No

Have a power of attorney? ___ Yes ___ No

 If yes, who is named as Agent? _____

Have a health care proxy? ___ Yes ___ No

Have a living will? ___ Yes ___ No

Expecting an inheritance? ___ Yes ___ No

Have Medicare? ___ Yes ___ No

 If yes: ID# _____ Part A _____ Part B _____

Have private health insurance? ___ Yes ___ No

If yes: Company ID# Monthly Premium

Have long-term care insurance? ___ Yes ___ No

 If yes: Company ID# Pay-out Benefit

■ **Additional Information**
