ROSE & ZUCKER, LLC
ATTORNEYS AT LAW
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DATE COMPLETED: _____ NAME OF STAFF PERSON: _____

LOCATION OF INTERVIEW: _____ CLIENT: _____

PERSON(S) SUPPLYING ANSWERS TO THESE QUESTIONS:

Name: _____

If not client, relationship to Elder(s): _____

Address: _____

_____

Home Telephone: ( ) _____ -_____ Work Telephone: ( ) _____-_____

Cell Telephone: ( ) _____ -_____ Email: _____@_____ . _____

Long-Term Care person present at interview? Y ____ N____ N/A ____

Community spouse, if any, present at interview? Y ____ N____ N/A ____

Other persons present at interview:

Name Address Telephone # Date of Birth

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

Primary Concerns (please circle those that apply or add own concerns):

Personal Safety: at home driving climbing stairs walking out in public

Personal Health: hearing vision balance memory mobility

dexterity hygiene dietaryconcerns agility concentration

Medical: forgetfulness sleeping comprehension eating medication

Other concerns: _____

_____

_____

Financial Information:

Gross Estate: HUSBAND WIFE

$_____ $_____

Other financial concerns:

_____

_____

SECTION 1 GENERAL INFORMATION

A. PERSONAL INFORMATION

	Husband	Wife
Full Name:	_____	_____
Other or Former Names:	_____	_____

U.S. Citizen: Yes _____ No _____ Yes _____ No _____

If not citizen, legal ____/_____/_____ ____/_____/_____

alien's date of entry to U.S.

Date of Birth: ____/_____/_____ ____/_____/_____

Place of Birth: _____ _____

Soc. Sec. #: _____-____-_____ _____-____-_____

Date and Place of Marriage: _____

Previously married? Y ___ N ___ Y ___ N ___

Number of Previous Marriages: _____ Number of Previous Marriages: _____

Date and Place of Previous Marriage: Pre- or Post-Nuptial Agreement? Y _____ N_____

HUSBAND WIFE

_____ _____

_____ _____

_____ _____

If yes, prior marriage end: Death / Divorce Death / Divorce
(Circle One)

If widowed:

Name: _____ Date of Death: _____/____/_____

Social Security Number: _____ - ____ - _____ Date of Birth: _____/____/_____

Domicile at death: _____

If divorced:

Ex-spouse's Name: _____ Date of Divorce: _____/____/_____

Court of Jurisdiction: _____

Veteran: Y ___ N ___ Y ___ N ___

If yes, branch of service: _____ _____

Husband Wife

Date of service:

From To From To

____/___/____ ____/___/____ ____/___/____ ____/___/____

B. HOME INFORMATION

Address: _____ _____

_____ _____

Home Tel.: ( ) _____-_____ ( ) _____-_____

Work Tel.: ( ) _____-_____ ( ) _____-_____

Cell Tel.: ( ) _____-_____ ( ) _____-_____

Fax: ( ) _____-_____ ( ) _____-_____

Email: _____@_____ . _____

C. KEY FAMILY INFORMATION

Contact information for children of this marriage:

Name Address Telephone # Date of Birth

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

Contact information for children from Husband's prior marriage(s):

Name Address Telephone # Date of Birth

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

Contact information for children from Wife's prior marriage(s):

Name Address Telephone # Date of Birth

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

Contact information for children who are disabled:

Name Address Telephone # Date of Birth

_____ _____ ( ) _____-_____ ____/_____/_____

_____ _____ ( ) _____-_____ ____/_____/_____

SECTION 2 ASSET INFORMATION

1. PERSONAL RESIDENCE

Owned: Y____ N ____ Rented: Y_____ N _____ If so, is there a lease? Y_____ N _____

If residence is rented, nature of rental: Single-Family house _____ Apartment _____ Condo _____

Residential Care _____ Life Care _____ Senior Housing _____ Subsidized? Y_____ N _____

If residence is owned: Deed: d: _____/___/_____ r: _____/___/_____ V _____ P _____

Did you transfer/gift your residence in the last 5 years? Y ____ N____ N/A ____

If you did transfer/gift your residence, did you retain a "life use?" Y ____ N____ N/A ____

a) Owner(s): _____

b) Form of Ownership: Joint ___ Tenants in Common ___ Individual ___ Trust ___

c) Estimated Fair Market Value (FMV): $ _____

d) Estimated amount of Mortgage: $ _____

e) Type of Mortgage: First _____ Second _____ HELOC _____ RAM _____

f) When purchased: _____ /____ /_____

g) Estimated purchase price: $ _____

h) Estimated Current Basis $ _____

(increased by death of previous spouse, etc. / Basis = equals cost + improvements)

i) Single Family: Y_____ N _____ If no, then number of Units: _____

j) Is there a child has that lived in the residence for at least 2 years? Y_____ N _____

If so, has the child provided personal care--care that might have kept Y_____ N _____

the parent(s) out of Long-Term Care (LTC)--to the parent(s)?

k) If other owner is a sibling, has that sibling lived in the residence Y_____ N _____

for at least one year?

l) Does the sibling have an equity interest in the home? Y_____ N _____

m) Does the LTC spouse (or potential) have a minor or disabled child? Y_____ N _____

n) If in LTC, does the LTC spouse intend to return home? Y_____ N _____

Notes:
_____
_____
_____
_____
_____
_____

2. OTHER REAL PROPERTY LOCATED OUTSIDE OF NEW JERSEY

Description and Location How Title is Held* Cost or Market Basis Value

_____ _____ $ _____ $ _____
_____ _____ $ _____ $ _____
_____ _____ $ _____ $ _____
_____ _____ $ _____ $ _____
_____ _____ $ _____ $ _____

*Explanation of title: Jointly? Jointly with rights of survivorship?
Tenants in common? In a Living Trust?
Qualified **P**ersonal **R**esidence **T**rust (QPRT)? Inherited? $_____

(For example, if you inherited your parent's home, what was home worth when you inherited it?)

3. BANKING/FINANCIAL ASSETS

Bank Account(s):

Financial Institution	Type of Acct.	Acct. # Title on Account	Balance

IRA(s):

Owner	Type of Acct.	Acct. # Beneficiary	Balance

CD(s):

Financial Institution	Type of Acct.	Acct. # Title on Account	Balance

Mutual Fund(s):

Broker / Agent	Type of Acct.	Acct. # Title on Account	Balance

Annuity(s):

Financial Institution	Type of Acct.	Acct. # Title on Account	Balance

Life Insurance:

Insurance Company	Owner	Policy #	Beneficiary	Life or Term	Cash Value

Long Term Care Insurance:

Insurance Company	Owner	Policy #	Beneficiary	Life or Term	Cash Value

Bonds – Savings or Other:

Bond	Type	Owner	POD	Description	Bond #	Market Value

Stocks:

Name of Stock Cert/Book	Owner	# of Shares	CUSIP	Unit Value/sh.

Retirement Accounts (i.e. 401(k)’s, 403(b)’s, Profit Sharing, Retirement):

Owner	Type of Acct.	Acct. # Beneficiary	Balance

Other assets: (For example, 2nd vehicle, etc.)

Owner	Type of Acct.	Acct. # Beneficiary	Balance

Please indicate any accounts that have been closed in the last 36 months (60 months if Trust Accounts):

Financial Institution: _____
Account #: _____
Owner(s): _____
Amounts: _____ Where did funds go?: _____

Financial Institution: _____

Account #: _____

Owner(s): _____

Amounts: _____ Where did funds go?: _____

4. INCOME

	Husband:		Wife:
a. Fixed Monthly Sources:			
Social Security	$ _____		$ _____
R. R. Retirement	$ _____		$ _____
Pension (_____)	$ _____		$ _____
V.A. Pension	$ _____		$ _____
Wages	$ _____		$ _____
Other (_____)	$ _____		$ _____
Totals:	$ _____		$ _____
Total of Both:		**$ _____**	
b. Non-Fixed Monthly Sources:			
Interest	$ _____		$ _____
Dividends	$ _____		$ _____
Rental (Net)	$ _____		$ _____
Other	$ _____		$ _____
Totals:	$ _____		$ _____
Total of Both:		**$ _____**	
c. Annuity			
Amount	$ _____		$ _____
Survivorship Rights	$ _____		$ _____
Not Deferred	$ _____		$ _____
Totals:	$ _____		$ _____
Total of Both:		**$ _____**	

d. Distributions

Are you taking any distributions from an IRA,401(k) or 403(b)? Y ____ N____ N/A ____

IRA/401(k)/403(b)	$ _____	$ _____
IRA/401(k)/403(b	$ _____	$ _____
Totals:	$ _____	$ _____

Total of Both: **$ _____**

e. Liens

Are there any existing liens against your real property: Y ____ N____ N/A ____

f. Debts

List all outstanding debts, including vehicle loans, credit card debt, and personal loans:

Debt:	Amount Owed:
_____	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

SECTION 3 CALCULATION FOR XIX QUALIFICATION

1. CHECKLIST OF EXEMPT ASSET	Husband	Wife
Burial plot owned	_____	_____
Burial Trust	_____	_____
Life Insurance	_____	_____

Life Insurance: Y____ N ____ Under $1500: Y____ N ____ Owner of policy: _____
Automobile Y____ N ____ Number: _____ (If more than one vehicle, list most valuable)
Year: _____ Make: _____ Model: _____ Approx. Value: _____

All furnishings allowed

Other real or personal property essential for self-support, cash, etc.
a) $ 1,600 for LTC spouse Y ____ N ____
b) $ 3,200 for couple

2. INHERITANCES (Attach a separate sheet to document this information.)

Any Expected Inheritances:	HUSBAND	WIFE
From:	_____	_____
From:	_____	_____

3. TOTAL NONEXEMPT ASSETS

Community Property (if applicable): _____

Husband's Separate Property: _____

Wife's Separate Property: _____

4. COST OF LIVING (EST.) PER MONTH

	Husband	Wife	Both
a) Housing If own, mortgage, taxes, etc.	_____	_____	_____
If rent, amount of monthly rental			
b) Insurance Health	_____	_____	_____
LTC	_____	_____	_____
Life	_____	_____	_____
Other (vehicle)	_____	_____	_____
c) Health and Medications	_____	_____	_____
d) Food	_____	_____	_____
e) Entertainment and travel	_____	_____	_____
f) Support for child(ren)	_____	_____	_____

g) Other _____ _____ _____

TOTALS _____ _____ _____

*Client(s) aware of property tax deferral option? Y _____ N _____
Currently using it? Y _____ N _____
Intend to in future? Y _____ N _____

Minimum monthly needs allowance?

a) Mortgage or rent _____

b) Real Estate Taxes _____ (exclude sewer use fees if listed sep.)

c) Home Owner's Ins. _____

d) Condo Fees _____

Total: _____

Base Shelter Amount: _____

SECTION 4 MEDICAL INFORMATION

PHYSICAL/COGNITIVE CONDITIONS (Diagnoses, if any)

1. Physical Conditions:

Husband:	Wife:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Cognitive Conditions:

Husband:	Wife:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. Medications / Taken for:

Husband:	Wife:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Activities of Daily Living:

	Husband	Wife

Feeds Independently	Y ___ N ___	Y ___ N ___
Bathes Independently	Y ___ N ___	Y ___ N ___
Uses Toilet Independently	Y ___ N ___	Y ___ N ___
Dresses Independently	Y ___ N ___	Y ___ N ___
Transfers Independently	Y ___ N ___	Y ___ N ___
Requires Supervison	Y ___ N ___	Y ___ N ___

5. Capacity (Initial indication only--may revise opinion upon review of other information.)

Husband	Y __ N __	Able to sign name:	Y __ N __
Wife	Y __ N __	Able to sign name:	Y __ N __

6. Primary Physicians

Husband:	Wife:
Dr. _____	Dr. _____
Specialty: _____	Specialty: _____
Address: _____	Address: _____
_____	_____
Phone: ( ) _____-_____	Phone: ( ) _____-_____
Fax: ( ) _____-_____	Fax: ( ) _____-_____

7. Specialty Physicians' Information:

Husband:	Wife:
Dr. _____	Dr. _____
Specialty: _____	Specialty: _____
Address: _____	Address: _____
_____	_____
Phone: ( ) _____-_____	Phone: ( ) _____-_____
Fax: ( ) _____-_____	Fax: ( ) _____-_____
Dr. _____	Dr. _____
Specialty: _____	Specialty: _____
Address: _____	Address: _____
_____	_____
Phone: ( ) _____-_____	Phone: ( ) _____-_____
Fax: ( ) _____-_____	Fax: ( ) _____-_____
Dr. _____	Dr. _____
Specialty: _____	Specialty: _____

Address: _____ Address: _____

_____ _____

Phone: ( ) _____-_____ Phone: ( ) _____-_____

Fax: ( ) _____-_____ Fax: ( ) _____-_____

Dr. _____ Dr. _____

Specialty: _____ Specialty: _____

Address: _____ Address: _____

_____ _____

Phone: ( ) _____-_____ Phone: ( ) _____-_____

Fax: ( ) _____-_____ Fax: ( ) _____-_____

8. Long-Term Care (LTC)

Is one spouse in LTC? Y _____ N_____ Husband____ or Wife ____

If so, date of entry (30-day continuous stay since entry): _____

Name of LTC facility: _____

Address: _____

Telephone Number: ( ) _____-_____

Administrator (contact person and position): _____

Is it a Medicaid-certified facility? Y _____ N_____

What is the cost of the facility? (Use private pay rate)

Daily rate: $_____

Monthly rate: $_____

Please list all dates of institutionalization: (if continuous time in hospital or skilled nursing facility exceeded 30 days) Married Couples only:

Husband:	FROM	TO
Name of facility: _____	____/___/____	____/___/____
Name of facility: _____	____/___/____	____/___/____
Name of facility: _____	____/___/____	____/___/____
Name of facility: _____	____/___/____	____/___/____

Wife:	FROM	TO
Name of facility: _____	____/___/____	____/___/____
Name of facility: _____	____/___/____	____/___/____
Name of facility: _____	____/___/____	____/___/____
Name of facility: _____	____/___/____	____/___/____

9. Hospital

Is one spouse in a hospital? Y_____ N_____ Husband _____ Wife ____

If so, what is the date of admission? ____/___/____ ____/___/____

Reason for admission: _____ _____

Additional comments regarding admission:

_____

_____

_____

Convalescence in LTC expected? Y ___ N ___ Y ___ N ___

If LTC placement expected, likely to return home? Y ___ N ___ Y ___ N ___

Has either spouse been admitted to the hospital in the past 2 years?

Husband: Y_____ N_____ Wife: Y_____ N_____

SECTION 5 NAMES OF OTHER PROFESSIONALS

Accountant:_____

Firm Name: _____

Address:_____

Telephone: ( ) _____-_____ Fax: ( ) _____-_____

Cell Telephone: ( ) _____-_____ Email: _____@_____.____

Tax Preparer:_____

Firm Name: _____

Address: _____

Telephone: ( ) _____-_____ Fax: ( ) _____-_____

Cell Telephone: ( ) _____-_____ Email: _____@_____.____

Financial Advisor: _____

Firm Name: _____

Address: _____

Telephone: ( ) _____-_____ Fax: ( ) _____-_____

Cell Telephone: ( ) _____-_____ Email: _____@_____.____

Insurance Agent: _____

Firm Name: _____

Address: _____

Telephone: ( ) _____-_____ Fax: ( ) _____-_____

Cell Telephone: ( ) _____-_____ Email: _____@_____.____

Other Attorney(s): _____

Firm Name: _____

Address: _____

Telephone: ( ) _____-_____ Fax: ( ) _____-_____

Cell Telephone: ( ) _____-_____ Email: _____@_____.____

Other: _____

Firm Name: _____

Address: _____

Telephone: ( ) _____-_____ Fax: ( ) _____-_____

Cell Telephone: ( ) _____-_____ Email: _____@_____.__

SECTION 6 CAREGIVER INFORMATION

Person(S) Responsible For Care

Who now has assistance responsibilities?

For Husband: _____

For Wife: _____

Are there any children or family member(s) who are not available or relied upon to help with management

Or other need of Husband's or Wife's care?

Y ____ N ____

If so, please list child or relative:

_____

_____

_____

Why?

_____

_____

_____

SECTION 7 INSURANCE INFORMATION

HEALTH INSURANCE:

Husband:

_____ HMO Description: _____

_____ Medicare Supp. Description: _____

_____ Other Description: _____

_____ Other Description: _____

Wife:

_____ HMO Description: _____

_____ Medicare Supp. Description: _____

_____ Other Description: _____

_____ Other Description: _____

SECTION 8 LEGAL DOCUMENTS

Does each have the following documents:	Husband	Wife
a. Will	Y ____ N ____	Y ____ N ____
Does client have originals? Y ___ N ____		
Does our office have copies? Y ____ N ____		
b. Trust, Revocable	Y ____ N ____	Y ____ N ____
Does client have originals? Y ___ N ____		
Does our office have copies? Y ____ N ____		
c. Durable Power of Attorney	Y ____ N ____	Y ____ N ____
If so, Statutory Form? Y ____ N ____		
Does client have originals? Y ___ N ____		
Does our office have copies? Y ____ N ____		
d. Living Will/Designation of Health Care Agent	Y ____ N ____	Y ____ N ____
If so, Statutory Form? Y ____ N ____		
Does client have originals? Y ___ N ____		
Does our office have copies? Y ____ N ____		
e. Designation of Conservator	Y ____ N ____	Y ____ N ____
If so, Statutory Form? Y ____ N ____		
Does client have originals? Y ___ N ____		
Does our office have copies? Y ____ N ____		
f. Real Estate Deed(s)	Y ____ N ____	Y ____ N ____
Does our office have copies? Y ____ N ____		

SECTION 9 CAPITAL GAINS / GIFTS

RESIDENCE: Capital gains

If own residence, or previously did:

a) Have you ever given away part or remainder of the house (retaining a life estate)? Y ____ N _____

If yes, please explain:

_____

_____

_____

_____

b) has owner(s) ever used capital gains exclusion? Y _____ N_____

($ 250,000 for single person; $ 500,000 for couple)

c) has owner(s) lived in residence for 2 of past 5 years? Y _____ N_____

GIFTS: Look-Back Period

Have either given gifts of $500 or more within the past 36 months ? Y ____ N ____

If yes, attach a Schedule of Gifts including to whom the gift was given, amounts and dates of each gift.

Any gifts/transfers made from a trust or to an irrevocable trust within the last 60 months? Y ____ N _____

If yes, attach a Schedule of Gifts including to whom the gift was given, amounts and dates of each gift.

Are you the beneficiary of any irrevocable trust? Y _____ N _____

If yes, please explain:

_____

_____

_____

Gift tax returns filed on any gifts (in excess of $ 10,000 per recipient)? Y_____ N_____

If so, indicate the nature of the gifts, amounts given and years returns were filed.

_____
_____
_____
_____

SECTION 10 GOALS OF CLIENT

GOALS OF CLIENT

____ I/We would like to be able to have the value of my home protected should I require long term medical care

____ I/We would like to be able to have my family members know what to do should I require long term medical care

____ I/We would like to know my spouse has enough to live comfortably should I pass away first

____ I/We would like to know my spouse would be able to protect cash savings should I require long term medical care

____ I/We would like to be able to have my children/loved ones benefit from my wealth

____ I/We would like to be able to have my family members know what my wishes are

____ I/We would like to know my children/loved ones are authorized to help when I need help

____ I/We would like to be able to avoid Probate

____ Other: _____

____ Other: _____

____ Other: _____

GENERAL COMMENTS AND OBSERVATIONS:

_____

_____

_____

_____

_____

ACKNOWLEDGEMENT:

THE INFORMATION CONTAINED IN THIS COMPREHENSIVE MEDICAID INTAKE ASSESSMENT IS

COMPLETE, CORRECT AND TRUE TO THE BEST OF OUR KNOWLEDGE AND BELIEF.

_____ _____
PRINT NAME SIGNATURE

DATE: _____/_____/_____

_____ _____
PRINT NAME SIGNATURE

DATE: _____/_____/_____

**********FOR OFFICE USE ONLY**********

HUSBAND WIFE

TOTAL COUNTABLE ASSETS: _____ _____
**********FOR OFFICE USE ONLY**********