



Attorneys & Counselors at Law

Faithfully Serving God & Our Clients

INFORMATION WORKSHEET

A. PERSONAL DATA

Name: _____ Spouse Name: _____
Address: _____ Address: _____
Date of Birth: _____ Date of Birth: _____

B. SERVICE INFORMATION

Did the veteran serve during one of the following war-times:
WWII 12/07/1941 - 12/31/1946 Korean War 06/27/1950 - 01/31/1955
Vietnam Conflict 02/28/1961 - 05/07/1975 Gulf War 08/02/1990 - Present

If yes, what branch of service, for how long, and what type of discharge did the veteran receive:
Branch: _____ Length of Service: _____ Type of Discharge: _____

C. CURRENT HEALTH / HOUSING INFORMATION - Nursing Home Spouse

Is the person alive? (If deceased, the following questions may be disregarded.) [] Yes [] No
Is the person suffering from any type of blindness? [] Yes [] No
Does the person need any assistance with the following (check all that apply):
[] Eating [] Bathing [] Dressing [] Toileting [] Transferring
Does the person suffer from a mental disability (i.e. Alzheimer's)? [] Yes [] No
Does the person still operate a motor vehicle? [] Yes [] No
Does the person live alone, without any assistance? [] Yes [] No
Does the person currently reside in an assisted living facility? [] Yes [] No
Does the person currently reside in a nursing facility? [] Yes [] No
Is the person receiving care through a caregiver agreement? [] Yes [] No

D. CURRENT HEALTH / HOUSING INFORMATION - SPOUSE

Is the spouse alive? (If deceased, the following questions may be disregarded.) [] Yes [] No
Is the spouse suffering from any type of blindness? [] Yes [] No
Does the spouse need any assistance with the following (check all that apply):
[] Eating [] Bathing [] Dressing [] Toileting [] Transferring
Does the spouse suffer from a mental disability (i.e. Alzheimer's)? [] Yes [] No
Does the spouse still operate a motor vehicle? [] Yes [] No

Does the spouse live alone, without any assistance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the spouse currently reside in an assisted living facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the spouse currently reside in a nursing facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the spouse receiving care through a caregiver agreement?	<input type="checkbox"/> Yes <input type="checkbox"/> No

E. MONTHLY INCOME

	Husband Monthly Income	Wife Monthly Income
Social Security Benefits	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Total Monthly Income	\$ _____	\$ _____

Do not include interest and dividend income on this form.

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

F. MONTHLY UNREIMBURSED MEDICAL EXPENSES (“UME”)

	Husband Monthly URME	Wife Monthly URME
Nursing Home	\$ _____	\$ _____
Assisted Living	\$ _____	\$ _____
Home Health Care	\$ _____	\$ _____
Medicare Premiums	\$ _____	\$ _____
Insurance Premiums	\$ _____	\$ _____
Monthly Prescription Cost	\$ _____	\$ _____
Monthly Other Cost	\$ _____	\$ _____
Total Monthly UME	\$ _____	\$ _____

G. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12 and quarterly expenses by 3)

\$ _____	Rent/Mortgage
\$ _____	Real Estate Taxes
\$ _____	Water
\$ _____	Sewer
\$ _____	Utilities (Heat, Electric) (1/12 of last 12 months)
\$ _____	Homeowner's insurance premium
\$ _____	Condominium fees
\$ _____	Total Monthly Housing Expenses

H. MONTHLY NON-SHELTER EXPENSES

(Please estimate)

\$ _____	Food
\$ _____	Medical
\$ _____	Clothing
\$ _____	Telephone
\$ _____	Transportation (including auto insurance)
\$ _____	Home Maintenance
\$ _____	Life Insurance Premiums
\$ _____	Health Insurance Premiums
\$ _____	Medicare Supplemental Insurance Premiums
\$ _____	Cable TV
\$ _____	Federal and State Income Taxes
\$ _____	Other
\$ _____	Total Monthly Non-Shelter Living Expenses

I. ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Husband	Wife	Joint	Liabilities
AUTOMOBILE				
ADDITIONAL AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
IRA/401(K)				
OTHER REAL ESTATE				
CARE FACILITY DEPOSIT				
OTHER				
OTHER				
TOTALS				

J. LIFE INSURANCE

COMPANY NAME (include address and policy No.)	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

K. GIFTS

Please list gifts made in excess of \$200.00 in any one month, to an individual or group of individuals, within the past 60 months:

Recipient _____	Maker _____
Date _____	Amount _____
Recipient _____	Maker _____
Date _____	Amount _____
Recipient _____	Maker _____
Date _____	Amount _____
Recipient _____	Maker _____
Date _____	Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

If so, please state details _____

L. CHILDREN (if applicable)

Are all of your children in good health? Yes No

Are any of your children receiving SSI or other forms of government entitlement? Yes No

Do any of your children live with you in your home? Yes No

M. PLANNING GOALS

Do they have any intent to benefit their children? Yes No

Are they looking for control and independence? Yes No

N. EXISTING ESTATE PLANNING DOCUMENTS

Will Yes No

Trust(s) Yes No

Medical powers of attorney Yes No

Financial powers of attorney Yes No

N. CERTIFICATION

The undersigned hereby represents to Haiman Hogue, PLLC that information contained in this intake form is accurate and complete, and that the undersigned understands that Haiman Hogue, PLLC will rely on this information for planning purposes. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Medicaid and or VA eligibility.

Dated: _____

Signature of Client or Client Representative: _____

Additional Comments: _____

Once completed, please return this form to:

Haiman Hogue, PLLC
2595 Dallas Parkway, Ste. 100
Frisco, Texas 75034
Phone: (469) 893-5337 | Facsimile: (214) 975-2540
jeff@haimanhogue.com
www.haimanhogue.com