CHECKLIST OF ITEMS NEEDED FOR
MEDICAID PLANNING FOR : ______________________________

PLEASE PROVIDE THE FOLLOWING CONTACT INFORMATION

ASSISTED LIVING/ NURSING HOME INFORMATION: (IF APPLICABLE)

NAME OF FACILITY: ____

LOCATION (CITY): ____

PRIMARY CARE PHYSICIAN:

NAME: ____

PHONE NUMBER: __________________________ FAX NUMBER: ___________________

ADVISORS / FAMILY MEMBERS:

NAME: ______________________________ RELATION: _____________________

ADDRESS: ____

____

PHONE : HOME # (   ) _______________ CELL # (   ) _______________

WORK # (   ) _______________ FAX# (   ) _______________

EMAIL: ____________________________________

NAME: ______________________________ RELATION: _____________________

ADDRESS: ____

____

PHONE : HOME # (   ) _______________ CELL # (   ) _______________

WORK # (   ) _______________ FAX# (   ) _______________

EMAIL: ____________________________________

NAME: ______________________________ RELATION: _____________________

ADDRESS: ____

____

PHONE : HOME # (   ) _______________ CELL # (   ) _______________

WORK # (   ) _______________ FAX# (   ) _______________

EMAIL: ____________________________________

NAME: ______________________________ RELATION: _____________________

ADDRESS: ____

____

PHONE : HOME # (   ) _______________ CELL # (   ) _______________

WORK # (   ) _______________ FAX# (   ) _______________

EMAIL: ____________________________________

Please complete the following chart for new Power of Attorney and Health Care Surrogate

APPLICANT: _____

POWER OF ATTORNEY

___HUSBAND/WIFE FIRST _____

___ORDER OF SUCCESSION ___TOGETHER/INDIVIDUALLY

___TOGETHER/JOINTLY ___TOGETHER/MAJORITY

1. _____
2. _____
3. _____
4. _____

HEALTH CARE SURROGATE

___HUSBAND/WIFE FIRST

___ORDER OF SUCCESSION ___TOGETHER/INDIVIDUALLY

___TOGETHER/JOINTLY ___TOGETHER/MAJORITY

1. _____
2. _____
3. _____
4. _____

SPOUSE: _____

POWER OF ATTORNEY

___HUSBAND/WIFE FIRST _____

___ORDER OF SUCCESSION ___TOGETHER/INDIVIDUALLY

___TOGETHER/JOINTLY ___TOGETHER/MAJORITY

1. _____
2. _____
3. _____
4. _____

HEALTH CARE SURROGATE

___HUSBAND/WIFE FIRST

___ORDER OF SUCCESSION ___TOGETHER/INDIVIDUALLY

___TOGETHER/JOINTLY ___TOGETHER/MAJORITY

1. _____
2. _____
3. _____
4. _____

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CHECKLIST OF ITEMS NEEDED FOR MEDICAID AND VA BENEFITS PLANNING

The items needed are for both the applicant and the spouse, if applicable.

Applicant Name: **Co-Applicant:**

Date: **Completed by:**

ITEM	APPLICANT		CO-APPLICANT	
	Required	**Received**	**Required**	**Received**
IDENTIFICATIONS				
Social Security Card				
Driver's License or Photo ID				
Birth Certficate *or*				
Passport *or*				
Baptismal Certficate				
MEDICAL INSURANCE				
Medicare Card				
HMO Card				
Medi-Gap Card				
Supplemental Insurance card				
MILITARY				
DD 214 Service Record				
Discharge Papers				
Marriage Certificate				
REAL ESTATE				
Warranty Deed				
Property 1 (Homestead)				
Property 2				
Vacant Land				
Rental property				
Timeshares				
Did you sell a piece of property within the last 5 years?			YES	NO
If so, provide closing/settlement statements and deposit of sale proceeds				
AUTOMOBILES, BOATS, TRAILERS, MOTOR HOMES				
Vehicle 1 Title or registration				
Vehicle 2 Title or registration				

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ITEM	APPLICANT		CO-APPLICANT	
	Required	Received	Required	Received
ESTATE PLANNING DOCUMENTS				
Fin. Durable Power of attorney				
Health Care Surrogate/ Proxy				
Living Will Declarations				
Trust Agreement Documents				
Last Will & Testaments				
Nuptual Agreements				
PRE-NEED FUNERAL/ BURIAL ARRANGEMENTS				
Plot Certficate/ Cemetary Deed				
Pre-Paid Funeral Arrangement Contract				
IF COMMUNITY SPOUSE PROVIDE THE FOLLOWING BILLS				
Utilities				
Water				
Electric				
Sewer				
Telephone				
Homeowner/Condo Fees				
Rent/Mortgage				
Health Insurance Premium				
Property Taxes				
Property Insurance				
Uncovered Medical Expenses				
STATEMENTS				
Please Provide the most recent statement for each account, and include every page				
Checking Account				
Savings Account				
Money Market Account				
CD's				
Annuity				
IRA for				
Brokerage Account				
Stocks and Bonds				
LIFE INSURANCE POLICIES				
LONG TERM CARE POLICIES				
PENSION STATEMENTS				
SOCIAL SECURITY STATEMENT OF BENEFITS				
TPQY (Third Party Query) call 1-800-772-1213 for copy of Awards Statement				

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