MEDICAID SPECIAL NEEDS TRUST DATA INTAKE FORM

R. Shawn Majette, VSB 19372
Thompson and McMullan, P.C.
100 Shockoe Slip
Richmond, Virginia 23219
804/649-7545 Telephone 804/649-0654 Facsimile
Email: smajette@t-mlaw.com

Thompson & McMullan Staff Use Only

T&M Staff : _____
Lawyer: _____
T&M Client Agreement date: _____
Date completed form received: _____

Please Print or Type

PERSON COMPLETING THIS FORM: _____
RELATION TO DISABLED PERSON (Self, parent, guardian, etc.):_____
ADDRESS: _____
_____
TELEPHONE # _____ (work) # _____ (home)
_____ (pager) # _____ (fax)

DISABLED PERSON

NAME: _____
Gender of Disabled Person: Lady: _____ Gentleman: _____
RESIDENCE ADDRESS: _____
MAILING ADDRESS CITY / STATE ZIP:
_____
_____
TELEPHONE NUMBER: Area Code: _____ - _____
DOB: _____AGE: _____ SSN: _____MARITAL STATUS:_____
PRESENT LOCATION (PATIENT/ROOM #): _____
RESIDENCE IN VIRGINIA COUNTY / CITY: _____
DATE OF DISABILITY (OR BIRTH, IF SINCE BIRTH): _____
DATE OF SOCIAL SECURITY / STATE DISABILITY
OFFICE DETERMINATION OF DISABILITY: _____

PROPOSED TRUSTEE - PRIMARY

This is the person who will be primarily responsible for the assets in the trust. There is usually a second person or bank or trust company to serve if this person is not able to serve.

NAME :_____
RESIDENCE ADDRESS:_____
COUNTY/CITY/ZIP:_____ TELEPHONE: _____
DOB:_____AGE:_____SSN:_____RELATION:_____

NOTE: The Trustee should not be a person with financial troubles and cannot be a person with a history of felony or larceny. ***In most cases the Trustee will be required to disclose his or her history of bankruptcy and felony convictions.***

PROPOSED TRUSTEE - SECONDARY

This is the person who will be responsible for trust assets when the primary trustee is not available to serve.

NAME :_____

RESIDENCE ADDRESS:_____

COUNTY/CITY/ZIP:_____ TELEPHONE: _____

DOB:_____AGE:_____SSN:_____RELATION:_____

NOTE: The Trustee should not be a person with financial troubles and cannot be a person with a history of felony or larceny. ***In most cases the Trustee will be required to disclose his or her history of bankruptcy and felony convictions.***

CONSERVATOR / GUARDIAN / POWER OF ATTORNEY

CURRENT AGENT UNDER POWER OF ATTORNEY OR ADVANCE MEDICAL DIRECTIVE; CURRENT GUARDIAN AND / OR CONSERVATOR, IF ANY:

NAME :_____

RESIDENCE ADDRESS:_____

COUNTY/CITY/ZIP:_____ TELEPHONE: _____

RELATION: _____ Agent _____ Guardian _____ Conservator

RELATION TO DISABLED PERSON: _____ (e.g., father, mother, friend)

TELEPHONE NUMBER:_____ / :_____ /:_____

DATE OF POWER OF ATTORNEY or ORDER: _____

ATTACH COPY OF POWER OF ATTORNEY OR GUARDIANSHIP / CONSERVATORSHIP ORDER

SPECIAL NEEDS OF DISABLED PERSON

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DISABLED PERSON FINANCIAL INFORMATION

INCOME

Social Security $_____/mo type:_____

Retirement $_____/mo source:_____

Interest $_____/mo source:_____

Other $_____/mo source:_____

ASSETS

Real Estate
Location:_____insured?_____
Tax Assessed value $_____ Taxes due?_____
(REAL ESTATE INFORMATION CONTINUED)
How held?_____ (sole, t/e, etc.)
Mortgage?_____
Motor vehicles
Make/Model_____Year_____Value $_____
Make/Model_____Year_____Value $_____
Other valuable personal property:
Describe:_____Value $_____
Bank Accounts:
Location:_____ Acct # _____ Value $_____
Location:_____ Acct # _____ Value $_____
Location:_____ Acct # _____ Value $_____

LIFE INSURANCE

KIND OWNER BENEFICIARY FACE AMT CASH AMT LOAN?
whole/
term

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

MEDICAL/HEALTH CARE INFORMATION

DIAGNOSIS

_____
_____
_____
_____.
Attending Physician:_____ Date last visit:_____
Address/Phone / Fax / Pager / E-Mail: _____
_____
Psychiatrist:_____ Date last visit:_____
Address/Phone / Fax / Pager / E-Mail: _____
_____
Hospital & Date of Admission:_____ Phone:_____
Social Worker:_____ Phone/Pager:_____
Nursing/Adult Home:_____ Phone/Pager:_____
Address:_____ Contact:_____

HEALTH INSURANCE

Medicare A____ B____ Claim # _____
Medicare Supplement_____ Claim # _____
Medicaid Claim # _____ City/County_____
Eligibility Date _____ Worker:_____

PERSON INJURY SETTLEMENT FUND?

If the fund which will be placed in the Trust is from a personal injury claim of the Disabled Person, please state the date of the injuries, describe the personal injuries, and give the name and address of the personal injury attorneys representing the Disabled Person. If there are pleadings in the case already, please provide them to Thompson & McMullan, P.C.

_____
_____
_____
_____
_____
_____
_____

Return to Elder Law Section
Thompson and McMullan P.C.
100 Shockoe Slip Richmond, Virginia 23219
804/698-6233 (V) 804/780-1813 (F)
smajette@t-mlaw.com

WARNING!

Note: As more fully described in the Disclaimer and Agreement which govern your use and limit the web site owner's liability of this web site:

1. No attorney client relationship is solicited, intended, or established by the creation, publication, downloading, observation, perception, use, or any other communication through this site.
2. Observation or perception of the materials posted on this web site does not establish any form of attorney-client relationship with the web site owner or any other entity.
3. This data collection form is provided as a convenience for general observers of this web site and as an aid to established clients of the web site owner.
4. **Confidential information is not solicited and should never be transmitted to the web site owner, or to any person affiliated with the web site owner, until and unless an attorney client relationship is established by a written legal services agreement signed by the web site owner and by the observer of the web site.**
5. The web site owner accepts no responsibility for the transmission of any confidential information, or any obligation as to such information which may received, in the absence of a written legal services agreement signed by the web site owner and the observer.