ELDER & DISABILITY LAW CLINIC

CLIENT INFORMATION WORKSHEET

(TO BE COMPLETED BY CLIENT PRIOR TO INITIAL CONSULTATION)

PART 1 - General Information

Name of Client: ______________________________ Date:________________

(Please list all names you use or have used, i.e. maiden names):

____

Current Address: ____

County:_____________________________

Is this a ___Nursing Home ___Group Home ___Assisted Living ___Other

Telephone Numbers: __________________(Home)

__________________(Cell)

__________________(Other important number)

Email address:__________________________

NOTE: If this is not your email address, whose is it?___________________

Other person we may contact on your behalf? ____

What is your current work status? ___Working ___Retired ___Disabled ___Unemployed

Are you:

- □ A Qualified Medicare Beneficiary
- □ Specified Low-income Medicare Beneficiary
- □ Disabled (explain disability:____)
- □ Receiving SSI or SSDI

Veteran? ___Yes ___No (Self / Spouse)
Do you have a service connected disability: ___Yes ___No
Are you currently receiving VA benefits? ___Yes ___No Explain:____________
Type of discharge? ______________________

Please indicate the services you are interested in:

- ☐ Estate planning: will, power of attorney, medical power of attorney, living will
- ☐ Long-term care planning: Medicaid, Medicare
- ☐ Guardianship and conservatorship
- ☐ Social Security: SSI, SSDI
- ☐ Probate Administration
- ☐ Elder Abuse and Consumer Protection

Please provide a brief narrative of the assistance you are looking to receive and any steps you have taken in this matter so far: *Please attach additional pages as necessary.*

<u>PART 2</u> – Medical Status (Complete ONLY if Applicable)

Conditions affecting care (check all that apply):

- □ Do you have Alzheimer's or related disorder?
- □ Do you have a chronic illness or disability that limits ability to work/care for self?
- □ Are you legally blind?
- □ Do you depend on other people for care?

Explain any health conditions: ____

Primary Care Physician: ________________________

Primary Cary Physician's Phone Number: _________________

Please list all prescription medications you are taking. *Attach additional pages as necessary.*

____

____

<u>PART 3</u> – Financial Information (Complete ONLY if Applicable)

Monthly Income:

$____________Husband (or single Person) $____________Wife/Other

Components of Income:	Husband	Wife
•Social Security:	$____________	$_____________
•Military Retirement	$____________	$_____________
•Pension	$____________	$_____________
•Survivor Benefits	$____________	$_____________
•Investment Income	$____________	$_____________
•IRA Distribution	$____________	$_____________
•Annuity Distribution	$____________	$_____________
•SSI	$____________	$_____________
•SSDI	$____________	$_____________
•Food Stamps	$____________	$_____________
•Other Income	$____________	$_____________

Monthly Expenses (must be able to document all expenses):

•Rent / Mortgage / Nursing Home	$_________________
•Utilities	$_________________
•Automobile Expenses	$_________________
•Prescription Medications	$_________________
•Unreimbursed Medical Expenses	$_________________
•Insurance	$_________________
•Miscellaneous Household Expenses	$_________________

Please list all debts. *Attach additional pages as necessary.*

____

____

Assets:

Item	**Owned by Single Person or Husband**	**Owned by Wife or other Person in Household**	**Owned Jointly**
Home			
Car			
Checking			
Savings			
CD's			
Non-IRA Stocks Bonds, Mutual Funds			
Non-IRA Annuities			
Other Real Estate / Timeshares			
Other Valuables (collections, etc)			
Retirement Funds (IRA's, 401(k)'s etc.)			
Life Ins. Cash Value			
Other Assets			
TOTAL (each column)	**$**	**$**	**$**

State Fair Market Value. If more than one account or item, show total value of all accounts. Reduce value of house or other property by any mortgage or lien. Please bring any documents you have (e.g., Bank statements, Investment account statements, Real Estate and Personal Property Tax Bills, Social Security Statements, W-2s, last year's tax return).

PART 4 – Medicaid or Veterans' Benefits (Complete ONLY if Applicable)

Date of Hospital/Nursing Home Admission: _________________

Any Prior Hospital or Nursing Home Admission? ________________

If so, when? ______________________; how long?_________________

Age of Person Needing Medicaid: ______________

Does Person needing Medicaid have:

___Will ___Financial Power of Attorney ___Health Care Power of Attorney

IF YES, PLEASE BRING THESE DOCUMENTS WITH YOU TO THE INITIAL CONSULTATION MEETING.

Does the Person needing Medicaid have a guardian? ___Yes ___No

If so, name of guardian:______________________________ (Please bring Guardianship papers)

Name of Spouse (If Applicable): _______________________

Age of Spouse: _______________

Names of Children (If Applicable): __________________________________

How many people live with you? ___________

List each person and that person's monthly income:

________________________ Relationship: ________________ $______________
________________________ Relationship: ________________ $______________

Are any of these people disabled? YES / NO

Do you pay residential property taxes on your home? YES / NO

Amount $______________

Do you pay your own gas/electric bills (even if included in rent)? YES / NO

Amount $______________

Do you care for any dependents? YES / NO

If so, how many and what is their relationship to you? ______________________________

____

Do you pay out-of-pocket on medical expenses that are not covered by Medicare (including Medicare and insurance premiums? YES/NO

Amount $ ______________/month

I certify that the information provided herein is true and accurate to the best of my knowledge and belief.

Signature:_________________________________

Date:____________________

Please return VIA mail to:

William & Mary Law School
Elder and Disability Law Clinic
PO Box 8795
Williamsburg, VA 23187

Fax: 757-221-1855

FOR OFFICE USE ONLY:
Total Assets:
Total Income:
Community Spouse Resource Allowance:
Total Spend Down:
Total Income:
~Allocated to IS:
~Allocated to CS:
Case Accepted: YES NO