HAIMAN+HOGUE

Attorneys & Counselors at Law

Faithfully Serving God & Our Clients

INFORMATION WORKSHEET

A. PERSONAL DATA

Name: _____

Address: _____

_____

Date of Birth: _____

Spouse Name: _____

Address: _____

_____

Date of Birth: _____

B. SERVICE INFORMATION

Did the veteran serve during one of the following war-times:

☐ *WWII* *12/07/1941 – 12/31/1946*

☐ *Vietnam Conflict* *02/28/1961 – 05/07/1975*

☐ *Korean War* *06/27/1950 – 01/31/1955*

☐ *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? ☐ Yes ☐ No
Does the spouse currently reside in an assisted living facility? ☐ Yes ☐ No
Does the spouse currently reside in a nursing facility? ☐ Yes ☐ No
Is the spouse receiving care through a caregiver agreement? ☐ Yes ☐ 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				
CERTIFICIATES 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