

# Medicaid Planning Information Form

Please complete the form to the best of your ability. This information will be used to assess Medicaid planning options for your family. It will be kept confidential.

4820 Glenway Ave.  
Cincinnati, Ohio 45238  
(513) 251-4900  
www.niehaus-law.com

Contact Person: \_\_\_\_\_

Relationship to potential Medicaid applicant: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

## **Information regarding the potential Medicaid applicant:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Residence address: \_\_\_\_\_

Home / Independent     Assisted Living     Full Nursing Care     Other: \_\_\_\_\_

If applicable, Name of Facility: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

## **Marital Status / Family**

Single

Married    Spouse's Name: \_\_\_\_\_    Spouse is on Medicaid?    Y    N

Widowed    Spouse's Name: \_\_\_\_\_    Spouse was on Medicaid?    Y    N

Divorced    Year of divorce: \_\_\_\_\_

Number of children: \_\_\_\_\_    Number of children in town & involved: \_\_\_\_\_

At least one child is blind or disabled    Name: \_\_\_\_\_

## **Education / Military Experience**

High School Graduate

Military Veteran

WWII Veteran

## **Legal Documents** (please bring to your appointment)

Will (date: \_\_\_\_\_)     Trust (date: \_\_\_\_\_)

Power of Attorney (date: \_\_\_\_\_)    Gift Provision?    Y    N

Named agent / attorney-in-fact: \_\_\_\_\_

Health Care Power of Attorney (date: \_\_\_\_\_)

Named agent / attorney-in-fact for health care: \_\_\_\_\_

