MEDICAID
INFORMATION FORM

1. Name of person who needs Medicaid:
____

2. Where is that person now? ____
____
If in hospital/care center, when admitted? ______________________________________
What level of care is the person receiving (Skilled Nursing, Assisted Living, Foster Care, etc)?
____
What level of care is expected in the foreseeable future (Skilled Nursing, Assisted Living, Foster Care, etc)?
____

3. Ill person's:
Birthday: ____________________________ Age: ___________________
Social Security Number: ____
Address: ____
____

4. Does the ill person have an attorney? If so, who:________________________________

5. Persons important in the life of the ill person (Name, Address, Telephone):
Spouse/Partner: ____
____
Adult Children: ____
____
____
____
____
____
Closest relative other than those above (for notice): _____________________________
____
Persons residing with ill person: ____
____
Persons depending on ill person for support: ____________________________________
____

6. Persons familiar with this situation (Name, Address, Telephone): ____________________
____
____
____
____
____
____
____
____

7. What is the mental condition of the person? ______________________________________
____
____
____

8. What is the physical condition of the person? _____________________________________
____
____
____
____

9. Is there a treating doctor? If yes,
Name: ____
Address: ____
____
Telephone: ____

Name: ____
Address: ____
____
Telephone: ____

10. Is there a health care representative or agent? ___ Yes, ___ No
If so, please provide a copy of the ***Advance Directive for Health Care*** *to the lawyer.*

11. Is there a financial agent under Powers of Attorney, or a trustee managing the ill person's financial affairs? ___ Yes, ___ No
If so, please provide a copy of the document to the lawyer.

12. May a home need to be sold to pay for care costs? ___ Yes, ___ No

13. Is there a spouse, a disabled child, and/or a blind or disabled sibling? ___ Yes, ___ No

14. If yes, where does this person live? ____
____
____
____

15. Describe the income and assets of the ill person (briefly):
Income: ____
____
____
____
____
Assets: ____
____
____
____
____

16. Describe the income and assets of the ill person's spouse (if married):
Income: ____
____
____
____
____
Assets: ____
____
____
____
____

17. Is the ill person a Veteran? ____

18. Is the ill person receiving funds payable by the Veterans Administration or the Oregon Department of Human Resources or any other federal/state program? ___ Yes, ___ No
If yes, describe: ____
____
____
____
____
____

19. Does ill person owe any money to anyone (including for medication or care costs)?
___ Yes, ___ No
If yes, describe: ____
____
____
____
____
____

20. Are any assets held jointly by the ill person and any others: ___ Yes, ___ No
If yes, describe: ____
____
____
____
____
____
____
____

21. Has the ill person OR the ill person's spouse made any gifts in the last five years:
___ Yes, ___ No
If yes, describe. Please show amount of gift, to whom the gift was made, and when the gift was made.
- Include transfers to trusts.
- Include sales for less than full fair market value. Include gifts to children or grandchildren or other relatives. Include gifts of cars. Include tuition payments for children or grandchildren. Include gifts to charity or the church. Include gift annuities and other charitable giving plans.: ____
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____
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____