MEDICAID (MEDI-CAL) ASSET PROTECTION TRUST CLIENT INTAKE QUESTIONNAIRE:

PLAN EARLY: Medicaid generally reviews asset transfers made during a "look-back" period (5 years under federal rules) before an application for long-term care. Transfers to an irrevocable trust inside that period can delay eligibility. Do not transfer or give away assets until we review your situation.

CONFIDENTIAL. A Medicaid asset protection trust is an IRREVOCABLE trust designed to help protect assets from long-term care costs while preserving them for your heirs. Medicaid is a joint federal-state program, and each state (including California's Medi-Cal program) has its own asset limits and rules, which change over time. If a question does not apply, write "N/A." If unknown, write "Unknown."

NAME OF THE CLIENT(s):

This form is completed by:

[__] The person(s) creating the trust [__] Family member / agent helping them

[__] Client 1 (Trustor): _____ Date of Birth: _____

[__] Client 2 (Spouse / Partner): _____ Date of Birth: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Syndicate Plan Member ID: _____ Name of person assisting (if any): _____

Preferred method of contact:

[__] Phone [__] Text [__] Email [__] Mail

Syndicate will meet privately with each person creating the trust to confirm that the decisions are their own.

PART 1 — GOALS & TIMING

1.1 Current situation:

[__] Planning ahead — no care needed now [__] Care likely needed within 5 years

[__] Currently receiving in-home care [__] Currently in assisted living / nursing home

[__] Applying for Medicaid / Medi-Cal now [__] Not sure

1.2 Interested in:

[__] Asset protection trust (irrevocable) [__] Special needs trust

[__] Trust for surviving spouse (will) [__] Pooled trust

[__] Protect the family home [__] Not sure — please recommend

1.3 What are your main goals (protect the home, leave an inheritance, qualify for care, provide for a spouse)?

_____

_____

Syndicate Subscription Legal Plans

PART 2 — PERSONAL & HEALTH INFORMATION

2.1 Marital status:

[__] Married [__] Registered domestic partner [__] Widowed

[__] Divorced [__] Single

2.2 Current living arrangement:

[__] Own home [__] Lives with family [__] Assisted living

[__] Nursing facility [__] Other

2.3 General health (optional): _____

2.4 Does either spouse have long-term care insurance? [__] Yes [__] No

2.5 Is either spouse a veteran or surviving spouse of a veteran? [__] Yes [__] No

2.6 Has a doctor raised concerns about memory or decision-making? [__] Yes [__] No

A person must have legal capacity to sign a trust. If capacity is a concern, other options (such as an agent under a power of attorney with gifting powers) may be needed.

PART 3 — FAMILY & BENEFICIARIES

Name	Relationship	Age	City / State	Disability / Special Needs?

3.1 Does any beneficiary receive SSI, Medicaid, or other needs-based benefits? [__] Yes [__] No

3.2 Are there family concerns (divorce, creditors, addiction) affecting any beneficiary? [__] Yes [__] No

If yes, explain: _____

_____

PART 4 — ASSETS & INCOME

Asset	Owner (1, 2, Joint)	Est. Value $	Loans $
Primary residence			
Other real estate			
Bank accounts			
Brokerage / investment accounts			
Retirement accounts (IRA / 401k)			
Annuities			
Life insurance (cash value)			
Vehicles			
Business interests			
Other			

4.1 Home address: _____

Retirement accounts generally cannot be transferred into a trust without being cashed out and taxed. We will review options for them separately.

Monthly Income	Client 1 $	Client 2 $
Social Security		
Pension		
VA benefits		
Annuity / retirement distributions		
Rental / other		

PART 5 — GIFTS & TRANSFERS (LAST 5 YEARS)

5.1 Any gifts, transfers, or below-value sales in the last 5 years? [__] Yes [__] No

Date	Asset / Amount	Given To	Relationship	Paid Anything?

PART 6 — TRUST DESIGN

The person creating a Medicaid trust generally cannot serve as trustee and cannot receive trust principal. Choose trusted people.

Role	Name	Relationship
Trustee		
Successor trustee		
Trust protector (optional)		

6.1 Assets you are considering placing in the trust:

[__] Home (you may keep the right to live there) [__] Real estate

[__] Bank / investment accounts [__] Other assets

6.2 Do you want to receive the trust's income during your lifetime? [__] Yes [__] No

Income paid to you may still count for Medicaid and may need to go toward care costs if you enter a nursing facility.

6.3 Do you want the ability to change who inherits (a limited power of appointment)? [__] Yes [__] No

6.4 How should the trust be distributed after your death (and your spouse's death)? _____

_____

6.5 Have you spoken with a CPA about income and capital gains tax effects? [__] Yes [__] No

PART 7 — EXISTING PLANNING DOCUMENTS

7.1 Documents in place:

[__] Will [__] Revocable living trust [__] Durable power of attorney

[__] Advance health care directive [__] None

Date signed / who prepared them: _____

7.2 Does your power of attorney allow your agent to make gifts or fund trusts? [__] Yes [__] No

ACKNOWLEDGMENTS

Please check each item to confirm you understand.

[__] An irrevocable trust generally cannot be changed or revoked, and I will give up control of assets placed in it.

[__] The trustee will not be able to give trust principal to me or my spouse.

[__] Transfers made within the look-back period may delay Medicaid / Medi-Cal eligibility.

[__] Medicaid rules vary by state and change over time; no result or eligibility date can be guaranteed.

[__] I should consult a tax professional about the tax effects of transferring assets.

PART 8 — DOCUMENT CHECKLIST

Please provide copies of the following, if available. Check each item you are including.

[__] Deeds & property tax bills

[__] Retirement account statements

[__] Income statements (SSA, pension, VA)

[__] Existing will / trust / POA / AHCD

[__] Medicaid / Medi-Cal notices

[__] Bank & investment statements (last 5 years)

[__] Annuity & life insurance policies

[__] Long-term care insurance policy

[__] Records of gifts or transfers

[__] Recent tax returns

Certification:

I/We declare that the information provided in this questionnaire is true, correct, and complete to the best of my/our knowledge, and that these decisions are my/our own. I/We understand this information is provided to Syndicate Subscription Legal Plans in confidence for the purpose of Medicaid trust planning.

Signed and dated this ____ day of _____, 20___

Signature (Client 1): _____

Print Name: _____

Signature (Client 2): _____

Print Name: _____

Please Print and Email to STEVE@STEVEMUELLERLEGAL.COM, or save this document as a PDF and email to STEVE@STEVEMUELLERLEGAL.COM,
Your information will be reviewed within one hour.