

DATE _____

REFERRAL SOURCE _____

YOUR NAME _____

ADDRESS _____

TEL # (W) _____ TEL # (H) _____ TEL # (C) _____

FAX # _____ E-MAIL _____

PURPOSE OF CONSULTATION _____

If you have come to discuss legal issues of another person, please also complete the following:

HIS/HER NAME _____

ADDRESS _____

TEL # _____

YOUR RELATIONSHIP TO THAT PERSON _____

For the person whose legal issues we will be discussing, please provide the following data: (If there is insufficient room for your answer, you may use the blank lines on the bottom of page 5.)

AGE _____ DATE OF BIRTH _____

MARITAL STATUS _____ SOC. SEC. # _____

CHILDREN OF MARRIAGE _____ S.S. BENEFIT _____

PRIOR MARRIAGE(S) _____ CHILDREN _____ PENSION(S) _____

MENTAL STATUS _____ OTHER FIXED INCOME _____

PHYSICAL STATUS _____ US CITIZEN _____ ALIEN ID# _____

VETERAN _____ SERVICE and ID# _____ IMMIGRATION STATUS _____

Please identify which of the following are owned by the person you have come to discuss:

	<u>Yes</u>	<u>No</u>	
HOME	<input type="checkbox"/>	<input type="checkbox"/>	
NAME(S) ON TITLE _____			
CAR	<input type="checkbox"/>	<input type="checkbox"/>	
NAME(S) ON TITLE _____			
SAFE DEPOSIT BOX	<input type="checkbox"/>	<input type="checkbox"/>	LOCATION OF KEY _____
NAME(S) ON BOX _____			
DURABLE POWER OF ATTORNEY	<input type="checkbox"/>	<input type="checkbox"/>	AGENT _____
HEALTH CARE PROXY	<input type="checkbox"/>	<input type="checkbox"/>	AGENT _____
WILL	<input type="checkbox"/>	<input type="checkbox"/>	EXECUTOR _____
LIVING TRUST	<input type="checkbox"/>	<input type="checkbox"/>	TRUSTEE _____
BURIAL PLOT	<input type="checkbox"/>	<input type="checkbox"/>	LOCATION _____
PRE-NEED FUNERAL AGREEMENT	<input type="checkbox"/>	<input type="checkbox"/>	COMPANY _____
BANK ACCTS. _____ INSTITUTION(S) _____			
NAME(S) ON TITLE(S) _____			
DESIGNATED BENEFICIARIES _____			
BROKERAGE ACCTS. _____ INSTITUTION(S) _____			
NAME(S) ON TITLE(S) _____			
DESIGNATED BENEFICIARIES _____			
BONDS/SECURITIES _____ TYPE(S) _____			
NAME(S) ON TITLE(S) _____			
DESIGNATED BENEFICIARIES _____			

IRAs _____ DESIGNATED BENEFICIARIES _____

FOR MEDICAID APPLICANTS ONLY:
Non-Medicaid applicants skip to page 6

In the last 5 years, have you made gifts valued at \$2,000 or more? If Yes: Amount(s), Date(s), Recipient(s) _____

Do you have an aide whom you want to keep? _____

Another phone contact _____

Mailing address for Medicaid notices _____

Full maiden name _____

City, state and country of birth _____

Mother's full maiden name _____

Previous public health coverage _____

Other persons in household _____

Full maiden name _____

City, state and country of birth _____

Mother's maiden name _____

Earnings from work _____

Employer's name _____

Gross income _____

How often paid _____

Living apart from spouse? _____

Deceased spouse? _____ Name _____

Loss or cancellation of health ins. provided by employer in past 6 months _____

Reason for loss or cancellation _____

Cost of rent, mortgage, property tax \$ _____ \$ _____ \$ _____

Separate water bills? _____ Amount \$ _____ Frequency _____

Paid or unpaid medical bills for past 3 months? _____

From whom? _____

Pending lawsuit for injuries? _____ What injuries? _____

Worker's Compensation case? _____

