MEDICAID CONSULTATION
INFORMATION NEEDED FOR APPOINTMENT

HIS FULL LEGAL NAME: ____

HIS SIGNING NAME: ____

HER FULL LEGAL NAME: ____

HER SIGNING NAME: ____

ADDRESS: ____

HIS BIRTHDATE:______________________HER BIRTHDATE: _______________________

HIS SSN:______________________________HER SSN: ______________________________

PHONE NUMBER: (W)______________(H)__________________(Cell) _________________

COUNTY OF DOMINICLE: ____

CHILDREN'S (OR AGENT'S) FULL NAMES BIRTHDATE

______________________________ ___________________________________

______________________________ ___________________________________

______________________________ ___________________________________

CHILDREN'S ADDRESSES AND PHONE NUMBERS

____

____

____

CHILDREN'S EMAIL ADDRESSES

____

____

____

PERSONAL REPRESENTATIVES OF WILL(S):
HUSBAND AND WIFE FOR EACH OTHER? YES ? NO ?
1. ____

2. ____

3. ____

AGENTS FOR PROPERTY POWER(S) OF ATTORNEY INCLUDING ADDRESSES AND PHONE:
HUSBAND AND WIFE FOR EACH OTHER? YES ? NO ?
1. ____

2. ____

3. ____

AGENTS FOR HEALTH CARE POWER(S) OF ATTORNEY INCLUDING ADDRESSES AND PHONE: HUSBAND AND WIFE FOR EACH OTHER? YES ? NO ?
1.

____
____

2. ____
____

3. ____
____

DISTRIBUTIONS OF ASSETS:
HUSBAND:

____
______

____
______

____
______

DISTRIBUTIONS OF ASSETS:
WIFE:

____
______

____
______

____
______

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