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Request for Benefit Info Form

How did you hear about our services / Who referred you?_____

Are you inquiring for yourself or someone else: (check one) ____ myself ____ someone else

First & Last Name of person needing benefits: _____ Age: _____ DOB: _____

Spouse's Name (of person needing benefits): _____ Age: _____ DOB: _____

The person needing benefits is: (check one): ___ Married ___ Single ___ Widow(er) ___ Domestic Partners

If you are the contact person, what is your relationship to the person above: _____

Contact person's first and last name: _____ Age: _____

Contact person's full Address: _____

Home Phone: _____ Cell or alternate phone: _____

EMAIL ADDRESS: _____

Check each topic below that you would like to cover during your FREE consultation

___ Veterans Benefits for Home Care & Assisted living (for Veterans and their spouses only)

Veteran's dates of service (if known): Dates entered / discharged (MM/YY) _____ *to* _____

Is your Veterans Benefit Planning for: _____ *IMMEDIATE NEED* _____ *Pre-Planning*

___ MediCARE Supplemental Insurances / MediGAP Coverage (all seniors: Vets & Non- Vets)

___ MedicAID Planning (all seniors : Vets & Non- Vets) ___ Email a copy of MEDICAID SECRETS REVEALED

___ Financial Planning - Making my money last longer & work harder (all seniors: Vets & Non- Vets)

___ Long Term Care insurance (LTCi) (all seniors: Vets & Non- Vets)

___ Maximizing Social Security Elections (all Retirees: Vets & Non- Vets)

My greatest concern is: _____

By signing below I give Scott Ferguson and his assigns my permission to contact me/us to provide further information to help us maximize our Government benefits and plan for our future. ***(You will not be contacted if not signed below)***.

Signature: _____ Date: _____

The preferred days or times to reach me are: _____

Other important information to note: _____

_____

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REQUEST FOR INFORMATION INTAKE FORM

Your appointment is scheduled for (Day, Date, Month, Year)_____
at _____ AM/PM to meet at (location)_____

You must send in this completed form for review prior to your appointment

Please include the cover page w/ the contact person's or representative's information

It is required that your POA or Representative attend your appointment

Tell us the about the person who would like to receive benefits (Potential Claimant)

Full name: _____ Age: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Was the claimant a Veteran? _____
Was the claimant's spouse a Veteran? _____Divorced from the Veteran? _____
In what war did the Veteran serve? _____
Dates of Service? _____ to _____
Did the veteran receive an honorable discharge? _____If not, What type?_____

Health Information

Would a Dr. say the claimant needs help with **one or more of these 5** activities of daily living (ADL's) such as bathing, dressing, transferring, toileting or eating? _____Yes _____No
What other types of daily activities would a doctor say the claimant need assistance with?

_____

Home Care / Provider Information

Does claimant currently live at home? _____Yes_ _____No
Is claimant receiving in-home care? _____Yes_ _____No
If so, what date did claimant begin receiving care? _____

What is the monthly amount claimant pays for this care? $_____
Who provides claimants at-home care? _____
Is the claimant's in-home care provider compensated? _____Yes_ _____No

If claimant is not receiving care, will they soon be receiving care ? _____Yes_ _____No

***** (continued on next page) *****

Community Information

Is the claimant currently in a community that provides care? _____Yes _____No
Is Spouse currently in a community that provides care? _____Yes _____No
If yes, which type of facility are they in? (Circle One)

CCRC Assisted living Independent Living Nursing Home

What is the date that they moved into their first community?_____
What is the name of the community? _____ State?_____
What is the monthly cost for this community? $_____

Insurance

Does the claimant have medical insurance ? Provider: _____ Monthly Premium $_____

Does the spouse have medical insurance? Provider: _____ Monthly Premium $_____

Does either claimant or Spouse have long-term care insurance? _____
If yes, does it help pay for their current care?_____
_____

Will either be applying for Medicaid at anytime in the future? _____Yes _____No

Financial Information:

Is claimant or spouse receiving any money from the VA? _____Yes _____No

If yes, what is the monthly amount received? $_____/ month

Income:

Please list the **monthly** amounts for both the veteran and spouse (if applicable). **Gr**oss / Net

Social Security	Claimant: _____	Spouse: _____	Gr/Net
Pension	Claimant: _____	Spouse: _____	Gr/Net
Annuity Income	Claimant: _____	Spouse: _____	Gr/Net
Other Income	Claimant: _____	Spouse: _____	Gr/Net
RMD's in past 12 Months	Claimant: _____	Spouse: _____	Gr/Net

(**R**equired **M**inimum **D**istributions from IRA's or other Qualified funds)

Total monthly income **Vet:** _____ **Spouse:** _____

Combined monthly income: _____

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Assets:

Checking	Claimant: _____	Spouse: _____
Saving	Claimant: _____	Spouse: _____
Stocks/Bonds/Mutual Funds	Claimant: _____	Spouse: _____
IRA/401K/Qualified Funds	Claimant: _____	Spouse: _____
Annuities (Qualified/Non-Qual)	Claimant: _____	Spouse: _____
Other Assets	Claimant: _____	Spouse: _____
Estimated Total	**Claimant:** _____	**Spouse:** _____

Is claimant / spouse listed as a **TRUSTEE** or have they established a **TRUST** in the past? Revocable / Irrevocable Date Est:_____

Life Insurance:

Face Value (Death Benefit):	Claimant: _____	Spouse: _____
Cash Value:	Claimant: _____	Spouse: _____

What plans do the claimant/spouse have for final expenses:_____

_____

Does claimant and/or spouse currently **own** a primary residence?_____
Location:_____ Value: _____ Mortgage Balance? _____
Does claimant and/or spouse own other real estate or investment property? _____
Location:_____ Value: _____ Mortgage Balance? _____
Does claimant and/or spouse plan on selling either the primary residence or other real estate in the near future? Yes _____ No_____ Please describe: _____

Other information that you feel we should know:_____

_____

Please bring any available supporting documents with you to your appointment

********** **Below For Office Use Only** **********

(RA/PB/IFT/PL$)

Forms provided:

VA Packet 1 (Veteran / Spouse)	Dr. Note 2680	CES (Care Exp Stmt)
SF-180 w/ cover	IFT Forms	Other: _____
Property Trust Intake	Property Release	Other: _____

Expectations: _____

Next Steps: _____

_____