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INSTRUCTIONS

1. This is a Fillable PDF form. Once completed, save the document as "Questionnaire - (your last name)" and email it to gio@aboutlivingtrusts.com. (As an example, save as: Questionnaire - Miller.)

2. Carefully complete the Questionnaire. Please do not leave any question unanswered. Select N/A (not applicable) if it does not apply to you.

3. Use the following Periods of War to answer question #31 in the Questionnaire:
   - WWII: . . . . . December 7, 1941 - December 31, 1946
   - Korea: . . . . . June 27, 1950 - January 31, 1955
   - Vietnam: . . . . . August 5, 1964 - May 7, 1975
   - Vietnam in Country: . . . . . February 28, 1961 - May 7, 1975

5. **We will contact you after receipt of the Questionnaire**. Gio is the Administrative Assistant handling VA benefits. If you need help, please call him **Monday, Wednesday,** from **9 AM to 3 PM** , or **Thursday** from **9 AM to 12:30 PM**, at 760-436-8832 x4 or contact him via email at gio@aboutlivingtrusts.com.

6. We will review your Questionnaire and call you to discuss our conclusions. We generally respond within 3 business days of receiving the Questionnaire. If you do not hear from us within one week of sending it to us, please give us a call because it probably means we never received it.

Call us if you wish to use our encrypted internet service to return the completed Questionnaire.

PRELIMINARY QUESTIONNAIRE FOR VETERANS BENEFITS AND MEDI-CAL

Date: _____

1. **Claimant Name:** _____ Age: ___
(The person in need of Aid & Attendance)
Claimant is: Vet ____ Spouse ____ Widow/Widower ____
Date of Birth: _____ Ph: _____
Address: _____
City: _____ St: _____ Zip: _____
County: _____
Number of Living Children: #____
Number of Deceased Children: #____
Is Spouse Living? _____ Name: _____
Spouse Date of Birth: _____ Age: _____
Social Security Number of Veteran: _____
Social Security Number of Spouse: _____
If claimant is other than Veteran or spouse:
Social Security Number of Claimant: _____
Claimant Date of Birth: _____ Age: _____

2. **The person referring you to us:**
Name: _____ Title: _____
Org: _____ Ph: _____
Address: _____ City: _____
St: _____ Zip: _____ Email: _____

3. **Your Name:** _____
Relationship to Claimant: _____
Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Ph: _____ Cell Ph: _____
Work Ph: _____ Fax: _____
Email: _____

4. **Who is helping Claimant make this claim (Contact Person)**
If same as person in #3, please skip to #5 below.
Name: _____ Age: _____
Relationship: _____
Address: _____
City: _____ St: _____ Zip: _____
Home Ph: _____ Cell Ph: _____
Work Ph: _____ Fax: _____
Email: _____

5. **Who does Claimant/spouse rely on for financial decision making.**
Name: _____ Age: _____
Relationship: _____
Address: _____
City: _____ St: _____ Zip: _____
Home Ph: _____ Cell Ph: _____
Work Ph: _____ Fax: _____
Email: _____

6. **Where does Claimant currently live?** (Select from dropdown menu or fill in under other.) Select an Answer

Other: _____

7. **What level of care is Claimant receiving?** (Select only one from the dropdown menu.) Select an Answer

8. **If Claimant does not currently reside in a facility, does Claimant plan to reside in a facility:** Select
If yes, planned date to enter: _____

9. **Facility in which Claimant resides or plans to reside: N/A** ☐

Name: _____ City: _____
Name of Contact: _____ Title: _____
Contact Ph: _____ Monthly Cost: $_____

10. **Does Spouse (if living) currently reside in a facility?** Select

If no: Does Spouse plan to reside in a facility: Select

If yes, planned date to enter: _____
Facility name: _____ City: _____
Name of Contact: _____ Title: _____
Contact Ph: _____ Monthly Cost: $_____

11. **Does Claimant use a Private Duty Home Care Agency?** Select

Name of Agency: _____ City: _____
Contact Person at Agency: _____
Ph: _____ Monthly Cost $_____

12. **Does Claimant use Independent/Private Individual that is not a family member for help?** Select

If yes, name of person: _____

13. **Does a family member provide Claimant help at home?** Select

If yes, name: _____ Ph: _____
Relationship: _____

14. **Does Veteran see a VA doctor?** Select

15. **Name, address, & phone number of spouse's primary doctor:**

_____

_____

_____

16. **Has veteran filed for health benefits through the VHA?** Select

17. **Is veteran receiving retired military pay (annuity)?** Select

18. **Is veteran receiving Tricare for Life?** Select

19. **Is Veteran rated by the VA as disabled?** Select
If so:
What is the current rating (the percent, not the type of disability)? ___%
What is the type of disability? _____

_____

20. **Did the Veteran serve in Vietnam?** Select
If yes, did he/she ever file a claim for conditions believed to be derived from that service? Select
(AGENT ORANGE ISSUE)

21. **If retired military veteran, is he/she receiving Service Connected Compensation that is combat related and has he/she filed for Combat Related Special Compensation through the DoD?** Select

22. **Has Claimant applied for Medi-Cal (as opposed to Medicare)?** Select

23. **Has Vet ever filed a claim with the VA before?** Select
If yes, type of Claim and Claim # (if known)? _____

24. **Has Claimant applied for or receiving V.A. Compensation?** Select

If yes, how much? $_____/month. What type of compensation? DIC? Pension? Other _____?

25. **If not approved for the V.A. Pension, how will you continue paying for the cost of care?** _____

26. **Are there dependent children?** Select
How Many? _____

27. **Are there dependent parents?** Select
How Many? _____

28. **If you are a widow(er) were you married to the Veteran at the time of the Veteran's death?** Select

Have you remarried: Select

If you have, is new marriage to a Veteran? Select

29. **If you are a surviving spouse of a Veteran, did you have any prior marriages to another Veteran?** Select

If so, did the marriage end due to the death of the prior Veteran? Select

If so, was that prior Veteran's death caused by anything that was service connected (an injury or disease)? Select

30. **Did the Veteran serve 90 consecutive days or more on Active Duty?** Select

31. **Did the Veteran serve at least one day of active duty during a period of war?** (See instruction sheet for war dates) Select

32. **Date of service entry** _____ **Date of discharge** _____

Date of service entry _____ Date of discharge _____

33. **Did the Veteran receive an honorable discharge?** Select
If not, what type of discharge did he receive? (Select from dropdown menu or fill in Other.) Select

Other _____ (Specify type)

34. **Was the Veteran a prisoner of war?** Select

35. **Does Claimant own a Long Term Care Policy?** Select
Date Purchased _____
Currently receiving benefits?
Benefit $_____/month

36. **Does Spouse (if living) own a Long Term Care Policy?** Select

Date Purchased _____
Currently receiving benefits?
Benefit $_____/month

37. **If Claimant has been diagnosed with Dementia or Alzheimer's can the Claimant answer the following questions correctly?** N/A ☐
    a. Who is the President of the United States? Select
    b. What year it is? Select
    c. Name all of his/her children? Select
    d. How much his/her Assets are worth? Select
    e. Do you want your children to take care of you? Select

38. **Do you or did you have a prenuptial agreement with your spouse?** Select

39. **Medical Questions** - Select Yes, No or Unsure for EVERY Medical issue listed below.)

Eyesight

Select Legally Blind

Diagnoses

Select Officially diagnosed Dementia
Select Officially diagnosed Alzheimer's
Select Wanderer or threat of flight
Select Terminally ill or under Hospice care

Ambulation and Capabilities

Select Still Drive
Select Able to walk unassisted
Select Dresses & undresses totally unassisted
Select Bathes totally unassisted
Select Goes to the bathroom totally unassisted
Select Able to keep self clean
Select Able to take & remember to take medication totally unassisted
Select Can take insulin or blood sugar checks totally unassisted
Select Can feed self totally unassisted
Select Can prepare own meals totally unassisted

Symptoms

Select Falls easily
Select Shortness of breath with mild exertion
Select Anxiety
Select Depression
Select Uses Oxygen as needed
Select Poor hearing
Select Completely Deaf

40. **Does Claimant have a reverse Mortgage?** Select

41. **# of children _____ & do they all get along?** Select

42. **Does Claimant have a Will?** Select

43. **Does Claimant have a Revocable Living Trust?** Select

44. **Does Claimant have a Power of Attorney for Finances?** Select

45. **Does Claimant receive income from an Irrevocable Trust?** Select

46. **Is there a court appointed conservator for Claimant?** Select

47. **What is the life expectancy of the Claimant?**
____ Yrs of life expectancy.

48. **Does veteran intend to sell the primary residence within the next 12 months?** Select

49. **If necessary, is Claimant willing to sell the residence now?** Select

50. **Did the Claimant's son or daughter ever serve in the military?** Select

51. **If so, did that son or daughter ever contribute financially to your support?** Select

52. **If neither you nor spouse was on active duty during WWII, what did you do during that period?** _____

53. **Did the Veteran serve at Camp Lejeune between Aug. 1, 1953 and December 31, 1987? If yes, did he/she ever file a claim for conditions believed to be derived from that service?** Select **(CONTAMINATED WATER ISSUE)**

LIST OF ASSETS

	Claimant	Spouse
All checking Acct's	$_____	$_____
All Savings Acct's	$_____	$_____
Money Market Accounts	$_____	$_____
All Certificates of Deposit	$_____	$_____
2nd Home	$_____	$_____
All Rental Properties	$_____	$_____
All Raw Land	$_____	$_____
All Timeshares	$_____	$_____
All Trust Deeds/Mortgages	$_____	$_____
Vehicles other than Primary Auto	$_____	$_____
IRA's	$_____	$_____
401K's	$_____	$_____
TSP's	$_____	$_____
403'B's	$_____	$_____
457	$_____	$_____
All Mutual Funds not in Retirement Plan	$_____	$_____
All Stocks Not in Retirement Plans	$_____	$_____
All Bonds Not in Retirement Plans	$_____	$_____
All Annuities Not in Retirement Plans	$_____	$_____
All Life Insurance **Cash Value**	$_____	$_____

TOTAL Assets Above . . . . . $_____ + $_____

Combined Total Assets Above . . . . . $_____

Residence Market Value. . . . . $_____
Primary Auto Value. . . . . $_____

Date you purchased residence (yr.) _____
Original Purchase Price $_____

Any Other Assets	$_____	$_____

LIST OF LIABILITIES

Reverse Mortgage (Balance) . . . . . $_____
1st Mortgage on Residence (Balance) . . . . . $_____
Other Mortgage on Residence (Balance) . . . . . $_____
Home Equity Line Of Credit (Balance Owed) . . $_____

Loan Balance on Primary Auto . . . . . $_____
Total Above Liabilities . . . . . $_____
==========

Mortgage (Balance) on 2nd Home	$_____	$_____
Mortgage (Balance) on all rental R.E. . . .	$_____	$_____
Mortgage (Balance) on all Land	$_____	$_____
Balance on **all** Credit Cards	$_____	$_____
Balance on Vehicle other than primary auto.	$_____	$_____
Balance on Personal notes payable	$_____	$_____
Other	$_____	$_____
Total Liabilities	$_____	+ $_____

Does Claimant (or spouse if alive) own an Irrevocable Burial Trust or Irrevocable Prepaid Burial Contract? Select

MONTHLY INCOME

	Claimant	Spouse
Pensions (Specify Source, i.e. IBM, General Motors, Military, VA, Government, etc.)		
Source		
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
Social Security	$_____	$_____
Rental Properties	$_____	$_____
Rent from Primary Residence	$_____	$_____
Farm Income	$_____	$_____
Long Term Care/mo. Benefit	$_____	$_____
401k's &/or TSP's	$_____	$_____
403b's	$_____	$_____
457	$_____	$_____
IRA's withdrawals/distributions	$_____	$_____
Annuities withdrawals	$_____	$_____
Interest from Banks/SL/C.U.	$_____	$_____
Dividends from Stocks, Mutual Funds	$_____	$_____
Other Income	$_____	$_____
Total monthly Income	$_____	+$_____
Combined Total Income	$_____	

COUNTABLE MONTHLY MEDICAL EXPENSES

	Claimant	Spouse
Assisted Living Facility	$_____	$_____
Home Health Care Provider	$_____	$_____
Nursing Home	$_____	$_____
Tri Care	$_____	$_____
LTC Policy Premium Payments	$_____	$_____
Medicare Part A	$_____	$_____
Medicare Part B	$_____	$_____
Medicare Part D	$_____	$_____
Medicare Supplement	$_____	$_____
Incontinence Supplies	$_____	$_____
Total Recurring Un-reimbursed Medical Expenses	$_____	$_____

Combined Total Monthly Medical Expenses ..... $_____

I declare under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

Dated: _____ Signature: _____
Claimant

Dated: _____ Signature: _____
Spouse (if any)

LIVING CHILDREN

Child's Name: ________________________ Age: _____ D.O.B _____
Spouse Name: ________________________ Age: _____ D.O.B _____
Address: ____
City: _______________ St: ______ Zip: ________
Child Present/Past Profession: _________________ Retired: Select
Spouse Present/Past Profession: ________________ Retired: Select
Home Ph: ______________ Cell Ph: _______________
Own Home Select Rent Home Select # of Children ___

Child's Name: ________________________ Age: _____ D.O.B _____
Spouse Name: ________________________ Age: _____ D.O.B _____
Address: ____
City: _______________ St: ______ Zip: ________
Child Present/Past Profession: _________________ Retired: Select
Spouse Present/Past Profession: ________________ Retired: Select
Home Ph: ______________ Cell Ph: _______________
Own Home Select Rent Home Select # of Children ___

Child's Name: ________________________ Age: _____ D.O.B _____
Spouse Name: ________________________ Age: _____ D.O.B _____
Address: ____
City: _______________ St: ______ Zip: ________
Child Present/Past Profession: _________________ Retired: Select
Spouse Present/Past Profession: ________________ Retired: Select
Home Ph: ______________ Cell Ph: _______________
Own Home Select Rent Home Select # of Children ___

*****Attach additional pages if there are more children******

Rev.03/19/18