



AN ELDER LAW FIRM

Office 501.251.1050 • Fax 501.358.4711

Little Rock

8221 Ranch Blvd., Ste A-1
Little Rock, AR 72223

Cabot

51 Financial Drive
Cabot, AR 72023

Fort Smith

4611 Rogers Ave., Ste 102
Fort Smith, AR 72903

Rogers

5001 W. Founders Way, Ste L10
Rogers, AR 72758

Date _____

ASSET PROTECTION QUESTIONNAIRE MARRIED COUPLE

Representative Contact Information

| | |
|--------------------------|--|
| Name: | |
| Address: | |
| City, State, Zip: | |
| Telephone: | |
| E-Mail: | |
| Relationship | |

PERSONAL DATA

(Husband) _____ (Wife) _____
Full Name Full Name

Street _____
Address

City _____ State _____ Zip _____

(Husband) _____ (Wife) _____
Birth Date Birth Date

(Husband) _____ (Wife) _____
SSN SSN

U. S. Citizen? Yes ☐ No ☐ U. S. Citizen? Yes ☐ No ☐

Veteran? Yes ☐ No ☐ Veteran? Yes ☐ No ☐

MEDICAL DATA

Name of Spouse in Nursing Home _____

Diagnosis _____

Name of Nursing Home: _____ Date Entered: _____

Does well spouse live: at home ☐ in a facility ☐

MONTHLY INCOME

| | Husband's Monthly Income | Wife's Monthly Income |
|---------------------------------|--------------------------|-----------------------|
| Social Security Benefits | \$ _____ | \$ _____ |
| Retirement Benefits (Gross) | \$ _____ | \$ _____ |
| VA Disability Benefit | \$ _____ | \$ _____ |
| Annuity Income | \$ _____ | \$ _____ |
| Rental Income | \$ _____ | \$ _____ |
| Long Term Care Insurance Income | \$ _____ | \$ _____ |
| Total Monthly Income | \$ _____ | \$ _____ |

Do not include interest and dividend income on this form.

If there is a pension, please list the gross pension amount, including any monies taken out for federal income taxes, health insurance, or any other reason.

MONTHLY COST OF NURSING HOME

| | |
|----------|---|
| \$ _____ | Daily Semi-Private Nursing Home Rate |
| \$ _____ | Medicare or Private Health Insurance Premiums |
| \$ _____ | Medicare Supplemental Insurance Premiums |
| \$ _____ | Prescription Drug Insurance Premiums |
| \$ _____ | Total Monthly Costs |

ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

| ASSET/LIABILITY | ASSET TOTAL | LIABILITY TOTAL |
|---|-------------|-----------------|
| CHECKING | | |
| | | |
| | | |
| SAVINGS | | |
| | | |
| | | |
| MONEY MARKET | | |
| | | |
| | | |
| CERTIFICATES OF DEPOSIT | | |
| | | |
| | | |
| RESIDENCE ADDRESS Provide Deed | | |
| NON HOME REAL ESTATE ADDRESS Provide Deed | | |
| AUTOMOBILE(S) ATV/RV/BOAT/TRAILER MAKE MODEL Provide Titles | | |
| BROKERAGE/CAP ACCOUNTS | | |
| | | |
| | | |
| MUTUAL FUNDS | | |
| | | |
| STOCKS | | |
| | | |
| BONDS | | |
| | | |

| ASSET/LIABILITY | ASSET TOTAL | LIABILITY TOTAL |
|-------------------------------------|-------------|-----------------|
| PROVIDE LAST 2 YEARS OF TAX RETURNS | | |
| ANNUITIES | | |
| | | |
| | | |
| | | |
| | | |
| TRADITIONAL IRA/RETIREMENT PLANS | | |
| | | |
| | | |
| CRYPTOCURRENCY | | |
| | | |
| PREPAID FUNERAL | | |
| BURIAL PLOTS | | |

LIFE INSURANCE

| COMPANY NAME (include address and policy No.) | TYPE | DEATH BENEFIT VALUE | FACE VALUE | CASH VALUE | INSURED | OWNER | BENEFICIARY |
|--|------|---------------------|------------|------------|---------|-------|-------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

GIFTS

Have you given/or sold real property, vehicles, all-terrain vehicles, or other items of value, as a gift in the last 60 months? ☐ Yes / ☐ No

Have added anyone else's name to any of your existing bank accounts, CDs, brokerage accounts, or any other assets in the last 60 months? ☐ Yes / ☐ No

Have removed your name from any existing bank accounts, CDs, brokerage accounts, or any other assets in the last 60 months? ☐ Yes / ☐ No

Have you make gifts or transfers in excess of \$100 in any one month, to an individual or group of individuals, within the past 60 months, or transferred assets to a trust within the past 60 months? ☐ Yes / ☐ No

If yes, please list below

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Recipient _____ Date _____ Amount _____

Have you ever filed a Federal Gift Tax Return? Yes ☐ No ☐

Do you have a Revocable or Irrevocable Trust? Yes ☐ No ☐

CHILDREN (if applicable)

| CHILD'S NAME | ADDRESS (With Zip Code) | TELEPHONE NUMBER | DATE OF BIRTH |
|--------------|----------------------------|---------------------|------------------|
| | | | |
| | | | |
| | | | |

Are any of your children disabled and/or receiving SSI or other forms of government entitlement? Yes ☐ No ☐

Does anyone live with you in your home? Yes ☐ No ☐

Have you previously applied for Medicaid? If yes, when? _____ Yes ☐ No ☐

Once completed, please return this form to:



Attention: Ben Jones

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Office 501.251.1050 • Fax 501.358.4711 • ben@aapglaw.com



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