ASSET PROTECTION WORKSHEET

WINBLAD LAW PLLC

Free Personal Analysis to Discover Asset Protection and VA/Medicaid Benefits You May be Eligible For

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CONFIDENTIAL – PROTECTED BY ATTORNEY CLIENT PRIVILEDGE

Date: _____ Phone _____ Email Address _____

Name _____ DOB _____ Spouse (if applicable) _____ DOB _____

Address _____

Veteran ☐ No ☐ Yes (Over) **Who** ☐ You ☐ Spouse ☐ Both **Dates of Service**: _____ Honorable Discharge ☐ Yes ☐ No

Current Information	**You**	**Spouse** ☐ NA	
Trust Planning	☐ Yes ☐ No	☐ Yes ☐ No	☐ Revocable ☐ Irrevocable Date: _____
Long-Term Care Insurance	☐ Yes ☐ No	☐ Yes ☐ No	Daily Benefit: $_____ Term: _____(yrs)
In a Nursing Home?	☐ Yes ☐ No	☐ Yes ☐ No	Mo. Cost: $_____ Unpaid Balance: _____

Your Health

You - Current Health ☐ Good ☐ Concern ☐ Problem (Details) _____

Spouse - Current Health ☐ Good ☐ Concern ☐ Problem (Details) _____

Have You Given Away Any Assets in The Last 60 Months? ☐ No ☐ Yes Total $ _____ Date_____

	You	**Spouse** ☐ NA ☐ Same
Do You Have Children:	☐ Yes How Many? _____ ☐ No	☐ Yes How Many? _____ ☐ No
Do Any Live With You:	☐ Yes How Many? _____ ☐ No	☐ Yes ☐ No
Any Children Disabled:	☐ Yes ☐ No	☐ Yes ☐ No

MONTHLY INCOME – (Pension, Soc. Sec, Etc.)	**YOU $_____**	**SPOUSE $_____**	**TOTAL $_____**
ASSETS (CURRENT VALUE)	**YOU OR JOINT NAME**	**IN SPOUSE NAME**	**TOTAL**
Cash, Checking, Savings, CD's, Money Market, etc.	$_____	$_____	$_____
Brokerage Accounts/Stocks, etc.	$_____	$_____	$_____
"Qualified" (IRA, 401K, etc.) Accounts	$_____	$_____	$_____
Life Insurance Cash Surrender Value	$_____	$_____	$_____
Death Benefit	$_____	$_____	$_____
Annuities (Current Value)	$_____	$_____	$_____
Home (Fair Market Value)	$_____	$_____	$_____
Other Assets_____	$_____	$_____	$_____
Total Assets	$_____	$_____	$_____
LIABILITIES/DEBTS	**YOU OR JOINT**	**SPOUSE**	**TOTAL**
Total Mortgage(s)/Other Debts & Liabilities	$_____	$_____	$_____
MONTHLY LIVING EXPENSES	**YOU OR JOINT**	**SPOUSE**	**TOTAL**
How much you spend each month to live	$_____	$_____	$_____
How much you spend each month on medical needs	$_____	$_____	$_____

Veteran Eligibility: Name:_____

ELIGIBILITY:

1. Is the person a veteran or surviving spouse of a veteran? ☐ Yes ☐ No
2. Did the veteran serve for at least 90 days active duty and one day during war time? (12/7/1941-12/31/1946; 6/27/1950-1/31/1955; 7/5/1964-5/7/1975 (2/28/1961 if they physically served in Vietnam); 8/2/1990- TBD ☐ Yes ☐ No
3. Did they receive discharge under honorable, general, or medical discharge? ☐ Yes ☐ No
4. Is Veteran/Spouse under 65 and unable to work due to disability or over 65? ☐ Yes ☐ No
5. Homebound? ☐ Yes ☐ No
6. Any of the Following: Blind, in Nursing Home, requires help dressing, bathing, or protective environment? ☐ Yes ☐ No

INCOME:	MONTHLY	
	(1) Veteran	(2) Spouse
Social Security		
Pension		
Other		
TOTAL		

ASSETS	(1) Veteran	(2) Spouse
Cash / Savings		
Investments/Brokerage		
Retirement		
Life Insurance • Face • Cash • Death Benefit	$ $ $	$ $ $
Home		
Other Real Estate		
Automobiles		
IRA Cash		
Annuity		
Business Interests		
Savings Bonds		

MEDICAL EXPENSES:	MONTHLY	
	(1) Veteran	(2) Spouse
Assisted Living		
Nursing Home		
In Home Care		
Day Programs		
Medications		
Co-Pays for Medicaid		
Medicare Supplements Part B/D		
Hygienic Supplies		
Health Insurance Premiums		
Long Term Care Premiums		
Expected Devices / Equipment		
Co-Pays		
Other		

Describe Medical / Mobility Issues:

Any Special Needs or Concerns:

_____

_____

_____

_____

_____