

NEW CLIENT INFORMATION

The information requested below will help MBRS to more quickly become familiar with your client's situation. If you do not know the answer to any of the questions, leave it blank.

Mr. _____
Mrs. _____

Legal Name (F/MI/L): _____

PERSONAL INFORMATION.....

Date of Birth: _____ Date of Death: _____

Social Security No.: _____

Type of Trust: _____ Does Trust have Power of Attorney? _____

Has a Guardian been appointed for the client? _____ If yes, who? _____

Guardian's Relationship to Client: _____

Has Social Security been notified of the Trust's authority to act on behalf of the client relative to Medicare? _____ Of the Guardian's authority? _____

Is client currently employed? _____ Has the client ever been employed? _____

If retired, when? _____ What type of Profession? _____

If retired, are client's Social Security benefits direct deposited to a bank? _____

If client is/was married: Is spouse working? _____ Employer: _____
Is spouse retired? _____ From: _____
Is spouse deceased? _____ Date of Death: _____

Client resides: In own home _____
In residential retirement complex or community _____
In Personal Care Home _____
In a nursing home _____
Other (explain): _____

Mailing address for above (include name of any facility):

Does client receive medical bills and insurance reimbursements at the above address? _____

If yes, would the client approve of a change in address to c/o the bank? _____

If no, at what address does the client receive mail? _____

Has the client resided out of the Country or in another state during the past two years? _____
Has the client received medical services in another state during the past two years? _____
If yes to either question, please explain: _____

IF CLIENT LIVES AT HOME:

(1) are caregivers employed in the home, such as private-duty nurses or aides? _____
If yes, name of agency (if applicable): _____

(2) are you aware of any plans to relocate him/her to a nursing facility? _____
If yes, when and where? _____

(3) what type of medical equipment is in use now, i.e., wheelchair, hospital bed, etc.?

_____ Purchased _____ Rented _____

_____ Purchased _____ Rented _____

(4) has any medical equipment been in use during past year? _____

Are there family members involved who may pay medical bills prior to forwarding information to the bank? _____

Does the client pay any medical bills before forwarding them to you? _____

If yes to either question, is the trust having difficulty obtaining the records needed to manage the client's medical expenses? _____

From your records or personal knowledge, please describe your client's chronic or recent medical problems, i.e., diabetes, blind, cancer, emotionally/mentally impaired, or "fell last year and fractured hip", etc.

Has the client been hospitalized during the past year? _____ When? _____
Where? _____ Reason? _____

Did client go to another facility for rehabilitation before returning to home/nursing home? _____
If yes, where: _____

How does the client obtain prescription drug medications?

Charged on pharmacy account and billed monthly? _____ Billed to: _____

Paid for at time of purchase? _____

Provided by nursing home and billed on monthly statement? _____

How does the client obtain medical supplies (including diapers)?

Charged on account and billed monthly? _____ Vendor? _____

Paid for at time of purchase? _____ Usually purchased at: _____

Provided by nursing home and billed on monthly statement? _____

Please share any other information that may be helpful to MBRS to better serve this client:

HEALTH INSURANCE POLICY INFORMATION.....

If your records do not include the information requested below, MBRS can identify your client's insurance policies if you will:

(1) Send a copy of the most recent premium notices for ALL insurance policies, including Medicare Part B (if Medicare coverage is not deducted from the monthly Social Security benefit);

.....OR.....

(2) Send a copy of your client's health insurance identification cards;

....OR....

(3) Send a copy of policy certificates or actual policy(ies);

....OR....

(4) Send records of any claims processed by each of the insurers.

List all health insurance policies (including Medicare) that are now in force:

1. _____ ID #: _____ Group #: _____

2. _____ ID #: _____ Group #: _____

3. _____ ID #: _____ Group #: _____

(List additional policies on a separate sheet of paper.)

Who receives the premium notices for each? (If different, list separately) _____

Who pays the premiums? _____ What is the mode of payment for each, i.e., monthly, quarterly, etc.? _____

If any policies are HMO's, who is the primary selected Primary Care Physician (PCP)? _____

Have there been any "elected" changes to any of these health insurance policies during the past year (i.e., added prescription drug coverage, dropped a long-term-care rider, etc.)? _____
Explain: _____

Is a deceased spouse listed as the policyholder on any of these policies (on premium notices)? _____
Explain: _____