KRAUSE AGENCY

MEDICAID COMPLIANT ANNUITY PLANNING INTAKE FORM
INSTITUTIONALIZED COUPLE

Information of individual completing this form:

Name: _____ Company: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Facsimile: _____

City/State/Zip: _____ / / Email: _____

ONCE COMPLETED, RETURN THIS FORM TO:

Krause Agency
1234 Enterprise Drive, De Pere, WI 54115
Phone: (800) 255-1932 Facsimile: (805) 683-6313
info@krauseagency.com

A. Client Data

(Husband)
Full Name: _____

(Wife)
Full Name: _____

Street Address: _____

City: _____ State/Zip: _____ /

(Husband)
Birth Date: _____

(Wife)
Birth Date: _____

U.S. Citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

U.S. Citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

B. Medical Data

Husband's Diagnosis: _____

Date Husband First Entered Care Facility: _____

Has the husband previously applied and been approved for Medicaid? ☐ Yes ☐ No

If yes, please explain: _____

_____

Wife's Diagnosis: _____

Date Wife First Entered Care Facility: _____

Has the wife previously applied and been approved for Medicaid? ☐ Yes ☐ No

If yes, please explain: _____

_____

C. Responsible Party(ies)

Please provide information regarding the Medicaid applicant's children, Power of Attorneys (POA), beneficiaries, or other responsible party(ies).

NAME	RELATIONSHIP	PHONE NUMBER	STATE OF RESIDENCE

Are any of the individuals named above the primary POA for the Medicaid applicant? ☐ Yes ☐ No

If yes, please name individual(s):

_____

_____

Are any of the individuals named above interested in learning more about Long-Term Care Insurance in order to secure their own financial future? ☐ Yes ☐ No

If yes, please name individual(s):

_____

_____

If any individuals indicate they are interested in learning more about Long-Term Care Insurance, they may be contacted by a Long-Term Care Insurance Advisor within or associated to our office.

D. Gross Monthly Income

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	$ _____	$ _____
Pension (Gross)	$ _____	$ _____
VA Disability Benefit	$ _____	$ _____
Other Income*	$ _____	$ _____
Total Monthly Income	$ 0.00	$ 0.00

*If other, please explain:

_____

_____

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.

E. Husband's Monthly Cost of Care

$ _____ Daily Private Pay Rate
$ _____ Health Insurance Premiums
$ _____ Medicare Supplemental Insurance Premiums
$ _____ Monthly Incidental Cost
$ _____ Monthly Prescription Cost
$ _____ Monthly Other Cost

Total Monthly Costs:
$ 0.00

The care facility is paid through _____(Month/Year)

E. Wife's Monthly Cost of Care

$ _____ Daily Private Pay Rate
$ _____ Health Insurance Premiums
$ _____ Medicare Supplemental Insurance Premiums
$ _____ Monthly Incidental Cost
$ _____ Monthly Prescription Cost
$ _____ Monthly Other Cost

Total Monthly Costs:
$ 0.00

The care facility is paid through _____(Month/Year)

G. Assets/Liabilities

Total countable resources as of the **first continuous period** of institutionalization: $ _____

Please insert the **current** value of each asset/liability in the appropriate space. Specify whether multiple accounts or one account for each type of asset.

Asset	Husband	Wife	Joint	Liability
Automobile				
Additional Automobile				
Checking Account				
Savings Account				
Other Bank Accounts				
Residence				
Mutual Funds				
Stocks/Bonds				
Annuities				
Retirement Accounts				
Roth IRAs				
Other Real Estate				
Care Facility Deposit				
Other				
TOTAL	0.00	0.00	0.00	0.00

Does the Ill Spouse own an irrevocable Funeral Expense Trust? ☐ Yes ☐ No

Does the Well Spouse own an irrevocable Funeral Expense Trust? ☐ Yes ☐ No

Are there any additional liabilities that should be considered (credit card debt, personal loans, outstanding medical bills, legal fees, etc.)? ☐ Yes ☐ No

If yes, please Explain

_____

_____

H. Life Insurance

TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER

I. Gifts

Has either spouse made gifts in excess of $100.00 in any one month, to an individual or group of individuals, within the past 60 months? ☐ Yes ☐ No

If yes, please Explain

_____

_____

_____

_____

J. Certification

The undersigned hereby represents to The Krause Agency that the information contained in this intake form is accurate and complete, and that the undersigned understands that The Krause Agency will rely on this information for purposes of developing a Medicaid Annuity plan. The undersigned hereby further understands that if information is omitted from this intake form, whether intentionally or unintentionally, that the information omitted may have a direct, and negative, impact on Medicaid eligibility.

Dated: _____

Signature of Client or Client Representative: _____