MEDICAID COMPLIANT ANNUITY PLANNING INTAKE FORM

SINGLE PERSON

Information of individual completing this form:

Name: _____ Company: _____

Address Line 1: _____ Phone: _____

Address Line 2: _____ Facsimile: _____

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

Are you, or are you completing this form on behalf of, a licensed insurance agent? ☐ Yes ☐ No

RETURN COMPLETED FORM TO:

Krause Group
1234 Enterprise Drive, De Pere, WI 54115
Phone: (866) 605-7437 Facsimile: (866) 605-7438
info@krause.com

A. Client Data

Client's Full Name: _____

Street Address: _____

City: _____ State/Zip: _____ / _____ Birthdate: _____

U.S. Citizen? ☐ Yes ☐ No

Veteran? ☐ Yes ☐ No

Surviving Spouse Of a Veteran? ☐ Yes ☐ No

B. Medical Data

Diagnosis: _____

Residence of Ill Spouse ☐ Home ☐ Nursing Home ☐ Assisted Living

If individual has already entered a care facility, please indicate the first date he or she entered on a continuous basis: _____

County the Medicaid applicant will be applying for benefits: _____

Has the applicant 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
			Select
			Select
			Select
			Select
			Select

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

Social Security Benefits	$
Pension (Gross)	$
VA Disability Benefit	$
Other Income*	$
Total Monthly Income	$ 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. 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)

If the nursing home facility is located in **New Hampshire, Kansas, Massachusetts, Montana North Carolina, Connecticut, Pennsylvania, West Virginia or Vermont**, Krause Financial Services **may** require the care facility's Medicaid per diem rate to develop the appropriate Medicaid Compliant Annuity plan.

As such, if applicable, please provide the Medicaid per diem rate: $_____

F. Assets/Liabilities

Please insert the 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 applicant own an irrevocable Funeral Expense Trust? ☐ Yes ☐ No

If the Medicaid applicant owns a home, will the home be sold or gifted as part of the Medicaid plan? ☐ Yes ☐ No

If yes, please explain

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

G. Assets/Liabilities

TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER

H. 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

I. Certification

The undersigned hereby represents to Krause Group that the information contained in this intake form is accurate and complete, and that the undersigned understands that Krause Group 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: _____

By way of this letter, Krause Group and its agents, including its agency affiliate Krause Brokerage Services (d/b/a in California as Krause Insurance Services) are not offering legal advice. The content outlined in this communication may not be suitable for every individual, in every state. As such, before employing or acting upon any one, or more, of the techniques, strategies, or opinions discussed in this letter, the reader should secure the services of a competent elder law attorney in their respective state. Furthermore, no inference is to be drawn that any of the insurance products provided by Krause Group have been reviewed or approved by any state Medicaid office. Krause Group makes no guarantee that the purchase of any insurance products will result in eligibility for Medicaid or any other assistance program.