



MEDICAID COMPLIANT ANNUITY PLANNING INTAKE FORM

MARRIED COUPLE

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

(Husband)

Full Name: _____

(Wife)

Full Name: _____

Street Address: _____

City: _____

State/Zip: _____ / _____

(Husband)

Birth Date: _____

(Wife)

Birth Date: _____

U.S. Citizen?

Yes

No

U.S. Citizen?

Yes

No

Veteran?

Yes

No

Veteran?

Yes

No

B. Medical Data

Name of Ill Spouse: _____

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 Ill Spouse previously applied and been approved for Medicaid?

Yes

No

If yes, please explain: _____

Name of Well Spouse : _____

Health of Well Spouse Poor Fair Good Excellent

Residence of Well Spouse Home Nursing Home Assisted Living

If he or she is in good health, the Well Spouse may be able to utilize a Long-Term Care Insurance policy as part of his or her estate plan. Is the Well Spouse interested in learning more about the Long-Term Care Insurance options that may be available?

Yes No

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 with 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	\$ _____	\$ _____

*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:

\$ _____

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

F. Monthly Shelter Expenses

\$ _____	Rent/Mortgage
\$ _____	Real Estate Taxes
\$ _____	Water/Sewer
\$ _____	Utilities (Heat, Electric)
\$ _____	Homeowner's Insurance
\$ _____	Other

Total Monthly Expenses:

\$ _____

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				

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 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: _____

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