



**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:

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

A. Client Data

(Husband) (Wife)
Full Name: _____ Full Name: _____
Street Address: _____
City: _____ State/Zip: _____ / _____
(Husband) (Wife)
Birth Date: _____ Birth Date: _____
U.S. Citizen? Yes No U.S. Citizen? Yes No
Veteran? 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	\$ _____	\$ _____

*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	Total Monthly Costs: \$ _____
\$ _____	Health Insurance Premiums	
\$ _____	Medicare Supplemental Insurance Premiums	
\$ _____	Monthly Incidental Cost	
\$ _____	Monthly Prescription Cost	
\$ _____	Monthly Other Cost	

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

E. Wife's Monthly Cost of Care

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

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				

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: _____

By way of this letter, The Krause Agency, 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 The Krause Agency have been reviewed or approved by any state Medicaid office. The Krause Agency makes no guarantee that the purchase of any insurance products will result in eligibility for Medicaid or any other assistance program.