



**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: \_\_\_\_\_

**ONCE COMPLETED, RETURN THIS FORM TO:**

**Craig Hannus**  
**craig@gateway-advisors.net**  
**Fax: (440) 445-0606**  
**Phone: (440) 709-6563**

**A. Client Data**

Client's Full Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State/Zip: \_\_\_\_\_ / \_\_\_\_\_ Birthdate: \_\_\_\_\_  
U.S. Citizen?  Yes  No Gender  M  F  
Surviving Spouse  Yes  No  
Veteran?  Yes  No 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

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

If yes, please name individual(s):

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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):

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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                 \$ \_\_\_\_\_

\*If other, please explain:

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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)

If the nursing home facility is located in **New Hampshire, Kansas, Massachusetts, North Carolina, Connecticut or Pennsylvania**, The Krause Agency **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	Value	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		
<b>TOTAL</b>		

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

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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

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### G. Life Insurance

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

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## I 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.