



KRAUSE FINANCIAL SERVICES

MEDICAID COMPLIANT ANNUITY PLANNING QUESTIONNAIRE

MARRIED COUPLE

Name:	
Address:	
City, State, Zip:	
Telephone:	
Facsimile:	
E-Mail:	

A. PERSONAL 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 _____

Prognosis _____

Course of Treatment _____

Where Ill Spouse Currently Resides _____

Name of Well Spouse _____

Health of Well Spouse _____

Where Well Spouse Currently Resides _____

If either spouse has already entered a nursing home, please indicate the name of the nursing home and the first date entered on a continuous basis _____

C. MONTHLY INCOME

	Husband's Monthly Income	Wife's Monthly Income
Social Security Benefits	\$ _____	\$ _____
Retirement Benefits (Gross)	\$ _____	\$ _____
VA Disability Benefit	\$ _____	\$ _____
Annuity Income	\$ _____	\$ _____
Rental Income	\$ _____	\$ _____
Total Monthly Income	\$ _____	\$ _____

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.

D. MONTHLY COST OF NURSING HOME

\$ _____	Monthly Nursing Home Cost
\$ _____	Monthly Incidental Cost
\$ _____	Monthly Prescription Cost
\$ _____	Monthly Other Cost
\$ _____	Total Monthly Costs

The nursing home is paid through _____ (month/year).

E. MONTHLY SHELTER EXPENSES

(Please divide annual expenses by 12, and quarterly expenses by 3.)

\$ _____	Rent/Mortgage
\$ _____	Real Estate Taxes
\$ _____	Water
\$ _____	Sewer
\$ _____	Utilities (Heat, Electric) (1/12 of last 12 months)
\$ _____	Homeowner's insurance premium
\$ _____	Condominium fees
\$ _____	Total Monthly Housing Expenses

F. MONTHLY NON-SHELTER EXPENSES

(Please estimate)

\$ _____	Food
\$ _____	Medical
\$ _____	Clothing
\$ _____	Telephone
\$ _____	Transportation (including auto insurance)
\$ _____	Home Maintenance
\$ _____	Life Insurance Premiums
\$ _____	Health Insurance Premiums
\$ _____	Medicare Supplemental Insurance Premiums
\$ _____	Cable TV
\$ _____	Federal and State Income Taxes
\$ _____	Other
\$ _____	Total Monthly Non-Shelter Living Expenses

G. ASSETS/LIABILITIES

(Please insert the value of each asset/liability in the appropriate space.)

Asset	Husband	Wife	Joint	Liabilities
AUTOMOBILE				
ADDITIONAL AUTOMOBILE				
CHECKING ACCOUNT				
SAVINGS ACCOUNT				
MONEY MARKET ACCOUNT				
CERTIFICATES OF DEPOSIT				
RESIDENCE				
MUTUAL FUNDS				
STOCKS				
BONDS				
ANNUITIES				
IRA				
OTHER REAL ESTATE				
NURSING HOME DEPOSIT				
OTHER				
OTHER				
TOTALS				

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

H. LIFE INSURANCE

COMPANY NAME <small>(include address and policy No.)</small>	TYPE	DEATH BENEFIT VALUE	FACE VALUE	CASH VALUE	INSURED	OWNER	BENEFICIARY

It is very important to know the cash value and the death benefit of your life insurance policy. To obtain the cash value of the policy, please call your insurance agent, or call the insurance company directly.

I. GIFTS

Please list gifts made in excess of \$100.00 in any one month, to an individual or group of individuals, within the past 60 months:

Recipient _____ Date _____ Amount _____
Recipient _____ Date _____ Amount _____
Recipient _____ Date _____ Amount _____
Recipient _____ Date _____ Amount _____

Have you ever filed a Federal Gift Tax Return? Yes No

If so, please state details _____

J. CHILDREN (if applicable)

CHILD'S NAME	ADDRESS (With Zip Code)	TELEPHONE NUMBER	DATE OF BIRTH

Are all of your children in good health? Yes No

Are any of your children receiving SSI or other forms of government entitlement? Yes No

Do any of your children live with you in your home? Yes No

K. THIRD PARTY COMPENSATION

If a licensed insurance agent, financial advisor, or other person is seeking compensation on this case, Krause Financial Services must know of their relationship prior to the development of a Medicaid plan. **Once a Medicaid plan is developed by way of a planning letter, no compensation – commissions or otherwise, will be made available to any third party.**

Will a third party be seeking compensation in this transaction? Yes No

L. CERTIFICATION

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

Once completed, please return this form to:

Krause Financial Services

Dale M. Krause, J.D., LL.M.

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De Pere, WI 54115

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Disclaimer:

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