



MEDICAID COMPLIANT ANNUITY INTAKE FORM

Information of individual completing this form:

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

ONCE COMPLETED, RETURN THIS FORM TO:

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

SECTION 1: PROPOSED MEDICAID APPLICANT

Name of proposed Medicaid applicant: _____ Sex: Male Female

Date of Birth: _____ State: _____

Is the proposed applicant currently receiving Medicaid benefits? Yes No

Is the proposed applicant currently residing in a long-term care facility? Yes No

If yes, please specify: Skilled Nursing Facility Assisted Living Facility Independent Living Facility

If no, please explain: _____

What is your relationship to the proposed applicant? Child Spouse Power of Attorney Other

If other, please specify: _____

SECTION 2: APPLICANT'S SPOUSE

Is the proposed applicant married? Yes No Name of spouse: _____

Spouse's Date of Birth: _____ State: _____

Does the spouse still reside at home? Yes No

If no, please explain: _____

Is the spouse in good health? Yes No

If no, please explain: _____

SECTION 3: BASIC FINANCIAL INFORMATION

What is the approximate value of the proposed applicant's monetary assets? _____
Note: Please include any jointly-held assets. Do not include the value of the home, vehicles, or any personal property, such as jewelry or artwork.

Does the proposed applicant own a home? Yes No Approximate value of home: _____

If yes, does the applicant intend to sell this home in the near future (please explain)? _____

Does the proposed applicant have any outstanding debts/liabilities? Yes No

If yes, please explain: _____

What is the proposed applicant's gross monthly income? _____
Note: Please include income from all sources, including pension, Social Security benefits, etc.

If applicable, what is the spouse's gross monthly income? _____
Note: Please include income from all sources, including pension, Social Security benefits, etc.

What are the proposed applicant's current monthly medical expenses? _____

SECTION 4: ADDITIONAL QUESTIONS

Is the applicant a veteran or the surviving spouse of a veteran? Yes No

If yes, please indicate the veteran's dates of service: _____

Have you sought advice from an elder law attorney? Yes No

If yes, please provide the name of the attorney and/or law firm: _____

Additional Comments: _____
