KRAUSE
FINANCIAL SERVICES

MEDICAID COMPLIANT ANNUITY QUOTE FORM

Information of individual completing this form:

Name:	
Company:	
Address:	
City, State, Zip:	
Telephone:	
Facsimile:	
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

Type of Case: ☐ Individual ☐ Community Spouse ☐ Gifting/Annuity Plan

Client Name: _____ **Sex:** ☐ Male ☐ Female

Date of Birth: _____ **State:** _____

County the Medicaid applicant will be applying for benefits: _____

Term of Annuity: _____ year(s), or _____ month(s), or ☐ Medicaid Life Expectancy

Premium Amount: $ _____ **Qualified Money (IRA, 401K, etc.)?** ☐ Yes ☐ No

Month of Medicaid Eligibility (if applicable): _____

Total Countable Resources (if applicable): $ _____

Monthly Income Amount (if applicable): $ _____

Monthly Nursing Home Cost (if applicable): $ _____

Is the community spouse or any of the responsible parties interested in learning more about long-term care insurance? ☐ Yes ☐ No

Additional Comments: _____

_____

_____