**Information of individual completing this form:**

**Name:**  **Address Line 1:**  **Address Line 2:**  **City/State/Zip:**

*A. Client Data*

Client’s Full Name:
Phone:
Facsimile:
Email:
Street Address:
City/State/Zip:

Gender at Birth:

Date of Birth:
U.S. Citizen? Yes No
Veteran? Yes No
Surviving Spouse of a Veteran?

*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/Parties*

Please provide information regarding the Medicaid applicant’s children, Power of Attorneys (POA), beneficiaries, or other responsible party(ies):

Are any of the individuals named above the primary POA for the Medicaid applicant? Yes No
If yes, please name individual(s):

*D. Gross 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. 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 and Year)

**If the nursing home facility is located in New Hampshire, Kansas, Massachusetts, North Carolina, Connecticut or Pennsylvania, Strong Foundation Systems 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.**

Automobile Value $ Liability $

Additional Automobile Value $ Liability $

Checking Account Value $ Liability $

Savings Account Value $ Liability $

Other Bank Accounts Value $ Liability $

Residence Value $ Liability $

Mutual Funds Value $ Liability $

Stocks/Bonds Value $ Liability $

Annuities Value $ Liability $

Retirement Accounts Value $ Liability $

Roth IRAs Value $ Liability $

Other Real Estate Value $ Liability $

Care Facility Deposit Value $ Liability $

Other Value $ Liability $

Total Value $ Liability $

Does the applicant own an Irrevocable Funeral Expense Trust? Yes/No

If the applicant owns a home, will the home be sold or gifted as part of the Medicaid plan?: Yes/No

If Yes, please explain:

Are there any additional liabilities that should be considered?: Yes/No

If Yes, please explain:

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:

*G. Life Insurance*

Policy 1 Type:

Policy 1 Death Benefit Value: $

Policy 1 Face Value (total value): $

Policy 1 Cash Value (put “0” if not applicable): $

Policy 1 Insured(s):

Policy 1 Owner(s):

Policy 1 Beneficiary/Beneficiaries:

Policy 2 Type:

Policy 2 Death Benefit Value: $

Policy 2 Face Value (total value): $

Policy 2 Cash Value (put “0” if not applicable): $

Policy 2 Insured(s):

Policy 2 Owner(s):

Policy 2 Beneficiary/Beneficiaries:

Policy 3 Type:

Policy 3 Death Benefit Value: $

Policy 3 Face Value (total value): $

Policy 3 Cash Value (put “0” if not applicable): $

Policy 3 Insured(s):

Policy 3 Owner(s):

Policy 3 Beneficiary/Beneficiaries:

Policy 4 Type:

Policy 4 Death Benefit Value: $

Policy 4 Face Value (total value): $

Policy 4 Cash Value (put “0” if not applicable): $

Policy 4 Insured(s):

Policy 4 Owner(s):

Policy 4 Beneficiary/Beneficiaries:

*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

*I. Certification*

The undersigned hereby represents to Strong Foundation Systems that the information contained in this intake form is accurate and complete, and that the undersigned understands that Strong Foundation Systems will rely on this information for purposes of developing a Medicaid Annuity plan. The undersigned further understands that if information is omitted from this intake form, whether intentionally or unintentionally, the omitted information may have a direct, negative impact on Medicaid eligibility.

Dated:
Signature of Client or Client Representative (print name):

**By way of this letter, Strong Foundation Systems, and its agents, 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 herein, 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 Strong Foundation Systems have been reviewed or approved by any state Medicaid office. Strong Foundation Systems makes no guarantee that the purchase of any insurance products will result in eligibility for Medicaid or any other assistance program.**