CRISIS MEDICAID SIMPLE QUOTE FORM

Attorney or Advisor's Contact Information

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

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

Client Name: _____ Sex: Male / Female

Date of Birth: _____ State: _____

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): $ _____

Additional Comments: _____

_____

Once completed, please return this form to:

AshBer
551 Windy Wood Lane
Wrightstown, WI 54180
Phone: 888.441.1595
Fax: 678.528.1290
amber@ashber.com