K-State Research & Extension, Marais des Cygnes District – Paola & Mound City Offices

Kathy Goul – Family & Consumer Science Agent and SHICK Counselor

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A Medicare appointment will be made after this intake form is returned to the Extension Office.

We will check plans for you and mail you the results **or** schedule an appointment if desired.

MEDICARE DRUG PLAN WORKSHEET

*** Items marked with asterisk (*) indicate required fields**

Beneficiary & Representative Name and Contact Information*

Name: _____

City, County, State, Zip:_____

Medicare Number:_____

Effective Date of Part A: _____ Part B:_____

Date of Birth:_____ Gender: ☐M ☐F ☐Other

Age Group: ☐64 or Younger ☐65-74 ☐75-84 ☐85 or Older

Is English Your Primary Language: ☐ Yes ☐ No If Not;_____

Phone: _____Email: _____

Representative First Name: _____

Representative Last Name: _____

Representative Phone: (_____) -_____ -_____

Representative Email: _____

Beneficiary Race * (multiple selections allowed):

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Other
- ❑ Not Collected

How Did You Learn About SHIP * (select only one):

- ❑ CMS Outreach
- ❑ Congressional Office
- ❑ Friend or Relative
- ❑ Health/Drug Plan
- ❑ Partner Agency
- ❑ Previous Contact
- ❑ SHIP Mailings
- ❑ SHIP Media
- ❑ SHIP Presentation
- ❑ State SHIP Website
- ❑ SHIP TA Center
- ❑ SSA
- ❑ State Medicaid Agency
- ❑ 1-800 Medicare
- ❑ Other
- ❑ Not Collected

Do you receive Social Security 'Extra Help? **If you received a letter about your Extra Help please attach it.**

☐Yes ☐No

Receiving or Applying for Social Security Disability or Medicare Disability * (select only one):

☐Yes ☐No

Are you eligible for extra help? ☐ Yes ☐ No From www.medicare.gov 9/2017

Extra Help Income/Resource Guidelines	Income Less Than		Resources Less Than	
Single	$1,518/mo		$14,100	
Married (living with spouse)	$2,058/mo		$28,150	

STOP – DO NOT COMPLETE BELOW – COUNSELOR WILL COMPLETE INFORMATION *: Date of Contact *:

Session Conducted By* : _____ Partner Organization Affiliation* :	ZIP Code of Session * :	County of Session * :	State of Session* :

Method of Contact * (select only one):

☐ Phone Call ☐Email ☐Web-based ☐Postal Mail/Fax ☐Face to Face at Session Location/Event ☐Face to Face at Home/Facility

MIPPA Contact *: ☐Yes ☐No	**Send to SMP:** ☐Yes ☐ No	**SIRS eFile ID: (*required if sending record to SMP)**

Monthly Income * (select only one): ☐ Below 150% FPL ☐ Above 150% FPL ☐ Not Collected

Assets * (select only one): ☐ Below 150% FPL ☐ Above 150% FPL ☐ Not Collected

Total Time Spent * Hours Minutes **Status *** ☐ In Progress ☐ Completed

Notes:	**Special Use Fields**
	Original PDP/MA-PD Cost:
	New PDP/MA-PD Cost:
	Field 3:
	Field 4:
	Field 5:

PLEASE ENTER PRESCRIPTION DRUGS

Which drugs do you currently take? (List the dosage and how often you take it per month.)
PLEASE PRINT CLEARLY OR ATTACH CURRENT PHARMACY LIST

Drug Name	Dosage (#mg/pill)	Frequency 30-Day Quantity (1 pill/day would be 30)

Is there a pharmacy you prefer to use? _____

Would you be willing to participate in a short survey about your experience w/Medicare appointment and plan comparison?_____NO____ YES_____ Email:_____

****Personal information is not shared with anyone.**