K-State Research & Extension, Marais des Cygnes District – Paola & Mound City Offices
Kathy Goul, FCS Agent & SHICK Counselor
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913 N. Pearl St., Suite 1, Paola, KS 66071 - 115 S. 6th Street, PO Box 160, Mound City, KS 66056
Form must be completed and returned to the Extension Office before assistance can be provided.
Once we receive your form, we will contact you with more information.

MEDICARE DRUG PLAN WORKSHEET

Beneficiary Name and Contact Information

Name: **Are you new to Medicare? YES NO**

Street Address:_____

City:_____ **County:** _____ **State:** _____ **ZIP:** _____

Date of Birth:_____ **Age Group:** ☐ 64 or Younger ☐ 65-74 ☐ 75-84 ☐ 85 or Older

Phone:_____ **Email:** _____

Gender: ☐ M ☐ F ☐ Other

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

How Did You Learn About This Service (select one):

☐ Friend or Relative ☐ Previous Contact
☐ Presentation ☐1-800 Medicare ☐ Other

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Extra help may be available - if your income & resources are within the following. From www.medicare.gov 2026

Extra Help Income/Resource Guidelines	Income Less Than	Resources Less Than
Single	$1,995/mo	$18,090
Married (living with spouse)	$2,705/mo	$36,100

Medicare Number:_____

Effective Date: Part A: _____ Part B:_____

Do you have a Medicare Advantage Plan? YES NO

Current Insurance: _____

Current Drug Plan: _____

Medicare.gov User Name:_____

Medicare.gov Password:_____

Does your Medicare.gov account have 2-factor authentication (they text you a code or send an email) set up? YES NO

I give the SHICK Counselor authorization to use my "Medicare.gov" login and password to generate drug plan comparisons from the information provided on this worksheet and/or to assist in enrollment in the plan of my choosing based on the comparison provided. I confirm that all information provided is truthful and accurate and I hereby release the Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining to my Medicare Part D enrollment. I acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug plan until the next open enrollment period, October 15, 2026 to December 7, 2026. I understand that the costs and covered medications quoted on the plan chosen may change.

Signature:_____ Date:_____

Please complete pharmacy information.

Pharmacy choice will have an impact on your overall plan options.

Pharmacy Preferences		Primary Concerns – Check All that Apply
1st Choice		☐ All Drugs Covered
2nd Choice		☐ Drug Deductible – none (Level Co-pays = higher premium)
Mail Order	☐ Yes ☐ No	☐ Lowest Total Premium + Drug Costs

Which drugs do you currently take? (List the dosage and how often you take it per month.)

PRINT CLEARLY or provide a current LIST of current prescriptions (not all purchases).

Do not list over the counter drugs or supplements.

☐ **I currently do not take any prescription drugs.**

Name of Prescription Drug	Dosage (#mg/pill)	Frequency 30-Day Quantity (1 pill/day would be 30)
For Example: Atorvastatin	10mg	30