2019

SHICK Senior Health Insurance Counseling for Kansas

To Be Completed By Office Staff

Name: _____

Appointment Date: _____

Appointment Time: _____

Counselor: _____

Medicare Prescription Drug Coverage Worksheet

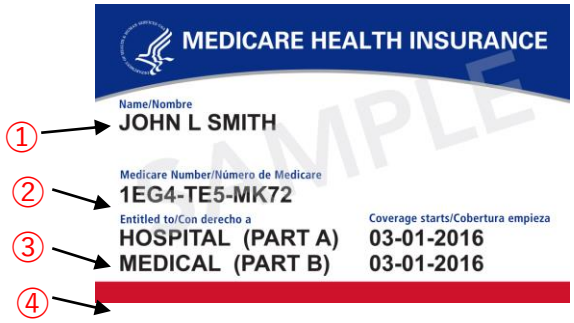
Please complete BOTH SIDES of this form and return to the Extension Office one week before your appointment if possible. Returning the form earlier will speed up your appointment.

1. **What is your name as it appears on your Medicare card**? ①

   _____

2. **What is your Medicare Claim Number?** ②

   _____



3. **What is your date of birth?**

   _____
   Month/Date/Year

4. **What is the effective date for your Medicare?**

   Part A ③ _____ **Part B** ④ _____
   Month/Date/Year *Month/Date/Year*

5. **What is your address**? _____

   City, State, Zip Code: _____

   Phone # _____

6. **What county do you live in?** _____

7. **List the pharmacy or pharmacies you use** (Please list Pharmacy name and city location):

   _____

8. **I have an account in MyMedicare.gov Yes ___ No ___** (If Yes please provide the following information)
   User Name: _____ Password: _____
   My Security question is: _____ Answer: _____

Are you eligible for extra help with your medications? Yes _____ No _____

Extra Help is available if:

- $ you have **income** at or below $18,972 per year ($1,581 per month) for an individual at or below $25,608 per year ($2,134 per month) for a married couple.
- $ **resources** below $12,980 for an individual or $25,720 for a married couple (excludes primary residence and one automobile).

If you qualify for Extra help:

Medicare will pay for some or all of your prescription drug costs.

For more information contact:
Deanna Turner
K-State Research and Extension River Valley District, Clay Center, 322 Grant Avenue, Clay Center, KS 67432
785-632-5335 dturner@ksu.edu

Please Complete Information on Back

9. **Which drugs do you currently take?** (Please also list the dosage, and how often you take it per month.)
*Only List **Prescription** Drugs*

Please Print Clearly

Prescription Drug Name *Please Print*	**Dosage** *Ex: 30 mg*	**30 Day Quantity** *Ex: 2 pills a day = 60*

9. **Name of Current Part D Plan**: _____

Please bring any recent letters you have received from Social Security or Medicare to your appointment. Also bring your Medicare Card.

SHICK Disclaimer

SHICK Counselor Name: _____

I have reviewed a minimum of two Medicare Part D Prescription Drug Plans and have chosen the following plan:

_____.

I give the SHICK Counselor listed above my authorization to enroll me in the above plan using the information I have provided. I confirm that all information provided is truthful and accurate and I hereby release the SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D enrollment herein. I also 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 which will be October 15, 2020 to December 7, 2020.

I also understand the costs and covered medications quoted on the plan I've chosen may be subject to change.

I give the SHICK Counselors and River Valley Extension District staff permission to use my MyMedicare.gov User Name and Password. If I do not have an account set up I give the SHICK Counselors and River Valley Extension District staff permission to create a User Name, Password and a security question.

Signature: _____ Printed Name: _____

For Office Use Only:

MyMedicare.gov

User Name _____ Password: _____

Security Question _____ Answer: _____

Current Plan Cost: $ _____ New Plan Cost: $ _____

Amount Saved: $ _____