Recd:_____ Comparison Run:_____ STARS:_____

Office Use Only

ECKAAA SHICK Counseling Worksheet

Name:_____

Release of Information

I give the ECKAAA SHICK Counselor authorization to use my personal/Medicare/Medigap information and/or my "myMedicare.gov" logon and password information:

- To generate my best three drug or Medicare Advantage plan comparisons from the information provided on this worksheet;
- To assist in enrollment in the plan of my choosing based on the comparison information provided.
- To assist me with any grievances, complaints, or questions I have regarding Medicare or other health insurance coverage, benefits determination and billing by accessing coverage determination or billing records as necessary to assist with my issue(s). The ECKAAA SHICK Counselor may need to discuss my health insurance and obtain coverage and billing information from Medicare, Social Security, one of the MCO companies for KS Medicaid, past/present employer, my prescription drug plan, my physician, pharmacy and/or hospital to discern available options for me and to resolve any issues/needs I may have with coverage and/or billing.

I confirm that all information I provide 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 to my Medicare Part D or Medicare Advantage 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 or Medicare Advantage plan until the next open enrollment period. I understand the costs and covered medications quoted on the plan I have chosen may be subject to change.

ECKAAA SHICK services are free of charge. (Donations to offset program costs are accepted.) The ECKAAA SHICK Counselor will provide me a copy of this consent form if I request. The original will be kept in my SHICK client file, which is stored in a secure manner. I may cancel my consent at any time and will notify SHICK if I choose to do so. I understand that once I have signed this consent form, I can expect my ECKAAA SHICK Counselor to help me without asking me to sign another consent form.

Signature:_____ Printed Name:_____
Date:_____

MyMedicare.gov Login Information:

If you have not set up this account, the ECKAAA SHICK Counselor can do so for you. This information will be given to you and a copy will be maintained in your SHICK client folder.

Username:_____ Password:_____

Signature:_____ Printed Name:_____
Date:_____

Please complete both sides of this worksheet and return to

SHICK, ECKAAA, 117 S Main St, Ottawa KS 66067

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Is Client Present? ___ Yes ___ No Verbal Permission Given to Create Medicare.gov Account? ___ Yes ___ No

Name of Representative from SHICK/ECKAAA Permission was given to:_____ Date:_____

Name:_____

Street/Mailing Address:_____

City:_____ Zipcode:_____

Phone:_____ County:_____ Race:_____

Email:_____ Birthdate:_____

Medicare #:_____ Effective Dates: Part A_____ Part B_____

Do you have a Health Savings Account (HSA) through your employer? _____

Are you eligible for Extra Help according to the guidelines below: _____
If you received a letter from the Social Security Administration about Extra Help, please attach it.

Single :	Income below $1615 per month/Resources below $14,610
Married (living with spouse):	Income below $2174 per month/Resources below $29,160

What coverage do you want information about? __ Part D Drug ___ Part C Medicare Adv __ MEDIGAP
Because MEDIGAP (Medicare Supplemental Insurance) does not have an Open Enrollment Period with a December 7th deadline, MEDIGAP information may be sent after the Open Enrollment Period closes.

***** If you take a generic medication, please write down that name rather than listing the brand name.**

	Complete Drug Name	Will you take generic if available?	Form (Capsule, Tablet, Spray, Injection, etc.)	Dosage/ Strength	Pills: # taken per day Other forms: # vials/ pens/ tubes used per month
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

If you take more than 20 medications, please list them on a separate page.

N**ame and address of your preferred retail pharmacy**: _____

Funded by the Older Americans Act through the Kansas Department on Aging and Disability Services. ECKAAA does not discriminate on the basis of race, color, nationality, origin, sex, age, religious belief or disability. If you feel you have been discriminated against, you have the right to file a complaint with the ECKAAA, 1-800-633-5621. (TDD: 1-800-766-3777)