**2019 For Office Use Only:** $ Before_____ $ After_____

Drug List ID:_____ Password Date:_____

## MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

NAME:_____

ADDRESS:_____

CITY: _____ ZIP:_____

PHONE:_____ COUNTY:_____ RACE:_____

EMAIL: _____

MEDICARE ID NUMBER:_____ BIRTH DATE:_____

EFFECTIVE DATE FOR PART A_____ FOR PART B_____

**Contact information if you are handling this worksheet for someone else:**
Name_____ Phone:_____

Address:_____

Email:_____

**1. Do you currently have a Part D Prescription Drug Plan?** Yes_____ No_____
If yes, what company?_____ what Plan?_____

**2. If you received a letter from Social Security about Extra Help please attach it.**

Are you eligible for extra help but not currently receiving it (see guidelines below)? Yes_____ No_____

**2019 annual income and resource limits to qualify for Extra Help**

**Single-** income less than $1,538/month & resources less than $14,100
**Married (living w/spouse)-** income less than $2078/month & resources less than $28,150
***Numbers based on information at www.medicare.gov and www.socialsecurity.gov, Sep 2018***

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**–HOW DO I GET HELP DECIDING WHAT PRESCRIPTION DRUG I NEED?**

1. **Complete this worksheet and return it to ECKAAA- 117 S. Main, Ottawa, KS 66067**
2. **You will be mailed/emailed a comparison of the top 3 plans w/an explanation and instructions.**
3. **If you would still like help or require further assistance call 785-242-7200 or 800-633-5621.**

## ***Please list all the prescription medications you take on the back***

**Donations are appreciated to help offset the costs for printing and mailing comparisons and enrollment assistance forms.**
**Checks may be made payable to ECKAAA/SHICK. Thank you for your generosity!**

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

Drug List ID: _____ Password Date: _____

$ Before: _____ $ After: _____

**Please print the info below**

| | Complete Drug Name | Will you take generic if available? | Capsule or Tablet | Dosage/ Strength | # of Pills Taken Per Day (Example: 1 tab 2 x daily) |
|---|---|---|---|---|---|
| **1** | | | | | |
| **2** | | | | | |
| **3** | | | | | |
| **4** | | | | | |
| **5** | | | | | |
| **6** | | | | | |
| **7** | | | | | |
| **8** | | | | | |
| **9** | | | | | |
| **10** | | | | | |
| **11** | | | | | |
| **12** | | | | | |

**Comments:**_____

**Please list your local pharmacy (we cannot run comparisons for mail order pharmacies). Please include name and address.**

**YOU WILL BE EMAILED OR MAILED PLAN INFORMATION ON THE TOP 3 PLANS FROM THE MEDICARE WEBSITE. CALL UPON RECEIVING IT IF YOU NEED FURTHER ASSISTANCE. 800-633-5621 or 785-242-7200.**

**RETURN THIS FORM TO:**
**ECKAAA, 117 S. MAIN ST., OTTAWA, KS 66067 or**
**FAX 785-242-7202 or EMAIL leslear@eckaaa.org**