2021 ECKAAA SHICK Medicare Part D Worksheet

Name_____

Street/Mailing Address_____

City_____ **Zip code**_____ **Phone**_____

County_____ **Race**_____ **Birthdate**_____

Email_____

Medicare #_____ **Part A Eff Date**_____ **Part B Eff Date**_____

Which are you currently enrolled in: Original Medicare w/Medigap plan? ____ Medicare Advantage plan with drugs? _____

Are you requesting a comparison of Medicare Advantage plans w/drug coverage for 2021? Yes_____ No _____

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:_____

***My*Medicare Account Login Information**: (PLEASE PRINT)
Username:_____ Password:_____

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

Signature:_____ Printed Name:_____

Date:_____

Username:_____ Password:_____

OVER

Do you currently receive Extra Help? _____

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

***** 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.					

If you take more than 13 medications, please list them on an attached page.

Please run for Retail pharmacy _____ Mail order _____ Both _____

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

RETURN THIS COMPLETED FORM TO:

East Central Kansas Area Agency on Aging, 117 S Main, Ottawa, KS 66067

OR leslear@eckaaa.org

785-242-7200 or 1-800-633-5621

While this is a free service, donations are appreciated as they help us provide services to more people.