ECKAAA SHICK Counseling Worksheet

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:_____

ECKAAA Medication Therapy Management Program

If I have a chronic condition, take five or more medications and/or have a history of falls or dizziness, I may be chosen to participate in ECKAAA's Medication Therapy Management Program. The program is intended to decrease the risk of adverse medication effects, improve my compliance with the doctor's prescription(s), and ultimately improve my health. A pharmacist will review my medication list and any self-reported diagnoses/surgeries and will make recommendations to discuss with my doctor(s). If I want to participate, I need to sign and date below.

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:_____
Name:_____

Street/Mailing
Address:_____

City:_____ Zipcode:_____

Phone:_____ County:_____ Race:_____

Email:_____ Birthdate:_____

Medicare #:_____ Effective Dates: Part A_____ Part B_____

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.					

If you take more than 12 medications, please list them on an attached page.

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

Do you want information about a Medicare Supplemental Insurance/MEDIGAP? _____