For Office Use Only: Drug List ID:_____Password Date:_____

Old Drug Costs;_____ New Drug Costs:_____

MEDICARE COUNSELING INTERVIEW WORKSHEET

1. **Complete this worksheet and return it to: SHICK/ECKAAA, 117 S. Main, Ottawa, KS 66067**
2. **Return this completed form no later than 1 week prior to your scheduled appointment to allow us time to prepare your information. If we don't have this form within this timeframe, your appointment may have to be rescheduled.**

Appointment Date:_____ Time:_____

What information are you wanting:_____

SECTION A:

Name:_____

Street/Mailing Address:_____

City:_____ State:_____ Zip code:_____ County:_____

Phone:_____ Race:_____ Gender:_____ Birthdate:_____

Marital Status:_____ Email:_____

Do you want your information by regular mail or email:_____

How did you learn about our Medicare counseling service:_____

Do you currently have employer-based insurance (through you or your spouse): _____ YES _____ NO

Do you currently have a retiree insurance plan: _____YES _____NO

If you are planning to retire, what is your planned retirement date:_____

Do you have an employer-sponsored Health Savings Account in your name: _____ YES _____ NO

Medicare Number:_____ Hospital Coverage (Part A) Effective Date: _____

Medical Coverage (Part B) Effective Date: _____

Contact information if you are handling this worksheet for someone else:

Name_____ Phone:_____

Address:_____

Email:_____

SECTION B:

If you have a MEDIGAP plan, indicate company:_____ What is the benefit plan:_____

If newly eligible for Medicare or wishing to change plans, what benefit plan are you interested in:_____

SECTION C:

If you have a Part D prescription drug plan, what is the name:_____

Are you eligible for **Extra Help** to pay for your drug coverage based on the guidelines below_____ YES _____ NO

Single- income less than $1,581/month & resources less than $14,600
Married (living w/spouse)- income less than $2,134/month & resources less than $28,720
Numbers based on information at www.medicare.gov and www.socialsecurity.gov, Jan 2019

Indicate your preferred local pharmacy with address. _____

Are you interested in using a mail-order pharmacy: _____ YES _____ NO

If you run out of room for your prescription medications, please attach an additional page listing those medications not listed below.

***If you take a generic medication, please write down that name, rather than listing the brand name. PLEASE **PRINT** 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					
13					
14					
15					
16					

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

Please mail this completed form to:

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

Or email this form to: **leslear@eckaaa.org**