ECKAAA 2027 Open Enrollment Worksheet

Return to 117 S. Main, Ottawa, KS 66067 by December 1st, 2026

NAME: _____

Please complete both sides and return to 117 S. Main, Ottawa, KS 66067

Preferred Contact Method: ☐ Email ☐ Phone Call ☐ In-person appointment

Do you travel multiple times per year? ☐ Yes ☐ No

Release of Information:

I give the ECKAAA SHICK Counselor authorization to use my personal/Medicare/Medigap information and/or my "Medicare.gov" login 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. 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 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 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. The ECKAAA SHICK Counselor will provide me with a copy of this consent form if requested. The original will be kept in my SHICK client file, which is stored in a secure manner. 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. I may cancel my consent at any time and will notify the SHICK program if I choose to do so.

Signature: _____ Printed Name: _____

Date: _____

Important: A Medicare.gov account is required for a personalized comparison. A general comparison can be run without a login.

Medicare.gov Login Information:

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

Username: _____ Password: _____

"This publication is supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award grant numbers 90SAPG0161, 90MPPG0081, & 2501KSMISH by ACL/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS, or the U.S. Government."

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Medicare Information

Name: _____ Birthdate: _____

Address: _____ City: _____

Zip Code: _____ County: _____

Phone: _____ Email: _____

Medicare #: _____ Part A Date: _____ Part B Date: _____

Are you a Veteran? ☐ Yes ☐ No

Are you eligible for Extra Help according to the guidelines below? ☐ Yes ☐ No

*If you've received a letter from the Social Security Administration about Extra Help, please attach it. *

Single: Income below $1,995 per month / Resources below $18,090

Married (living with spouse): Income below $2,705 per month / Resources below $36,100

Prescription Drug Information

IMPORTANT – If you have **multiple** medications, please attach a list from your pharmacy **after** your most recent Doctor's appointment. If you have an upcoming doctor's appointment, please **wait** until after that to turn in the worksheet.

Please list your current medications- If you need more room, please attach a separate page to this form.

Drug Name	Generic Option?	Drug Form	Dosage Amount	Drug Amount / # Days
	Yes / No			
	Yes / No			
	Yes / No			
	Yes / No			
	Yes / No			
	Yes / No			
	Yes / No			

Preferred retail pharmacy: _____

For Medicare Advantage Plans Only:

If you need information about a Medicare Advantage plan, please provide the names of your medical providers and their addresses, as well as hospitals and facilities you utilize.

_____

_____

_____

Drug Plan Premium Payment

If an ECKAAA SHICK Counselor enrolls you into a drug plan, do you want the premiums deducted from your Social Security / Railroad Retirement Benefits or billed directly (bank account autopay) by the drug plan?

SSA/RRB: _____ Direct Billing: _____