Date: _____ **Time:** _____ **Counselor:** _____

Circle Chosen Appointment Option: IN-PERSON PHONE VIDEO

Medicare Prescription Drug Coverage Worksheet

1. What is your name as it appears on your Medicare card? ①

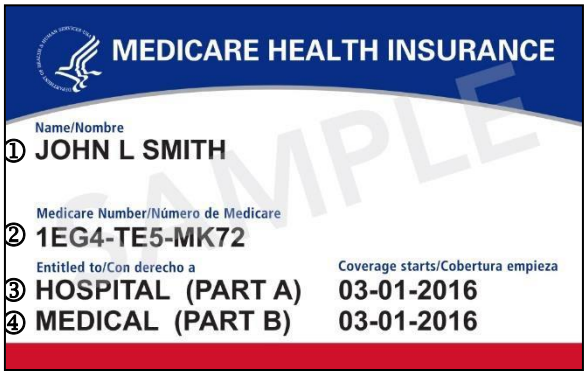
_____

2. What is your Medicare Claim Number? ②

_____

3. What is your date of birth?

_____
Month/Date/Year



4. What is the coverage start date for your Medicare?

③Part A _____ ④Part B _____
Month/Date/Year *Month/Date/Year*

5. What is your Zip Code?_____ County?_____

Address, City, State _____

Phone # _____ Email _____

Questions 6 & 7 are optional. This information can help determine if you are eligible for Extra Help with Medicare Part D costs.

6. Check the **ONE** box that best describes your **INCOME**.

Single, widowed, divorced, or live apart from my spouse and:	Married and:
☐ My annual gross income is less than $20,388	☐ Our annual gross income is less than $27,468
☐ My annual gross income is greater than $20,388	☐ Our annual gross income is greater than $27,468

7. Check the **ONE** box that best describes your **LIQUID ASSETS**. Liquid assets are the total value of your savings, investments, and real estate. Do not include your primary home, vehicles, burial plots, or personal possessions.

Single, widowed, divorced, or live apart from my spouse and:	Married and:
☐ My assets are $14,010 or less	☐ Our assets are $27,950 or less
☐ My assets are greater than $14,010	☐ Our assets are greater than $27,950

8. What is the name of your current Medicare Prescription Drug coverage?

_____

9. Do you have a Medicare.gov account? ☐ Yes ☐ No **If Yes, please bring your log in information.**

10. How did you hear about us? ☐ Friend/Relative ☐ Previous Contact ☐ Media ☐ Mailing ☐ Website ☐ Presentation ☐ Other _____

OVER ➡

11. Please list each prescription drug you take currently, the dosage, and a 30-day quantity. DO NOT add over the counter medications. Specify if the drug is a capsule or tablet. If you take Metoprolol, specify if it is Tartrate or Succinate. If you don't know, please clarify with your pharmacist. **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

DRUG NAME	DOSAGE	30- DAY QUANTITY
EX: Metoprolol Succinate	25 mg tablet	30 X (2/day) = 60

12. **List the pharmacy or pharmacies you use. (Required)**

_____

PLEASE RETURN THIS FORM IMMEDIATELY

Mail to: NWKAAA – Part D
PO Box 610
Hays, KS 67601

OR

Drop off at: NWKAAA
510 W 29th St
Hays, KS