SHICK Senior Health Insurance Counseling for Kansas

PLEASE PRINT

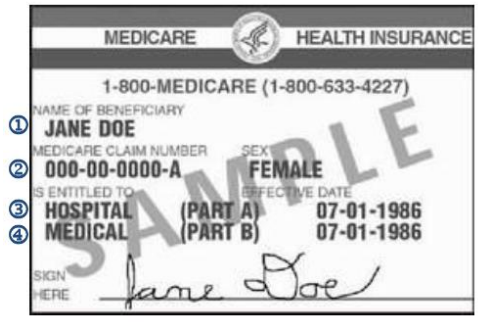
Appt. With: _____
Appt. Date: _____
Appt. Time: _____

1. Name as it appears on your Medicare Card: ①

_____

2. Medicare Claim Number including the letter(s): ②

_____



3. Date of Birth: _____/_____/_____

4. Effective dates on your Medicare Card:

Hospital (Part A): ③ _____/_____/_____
(month/date/year)

Medical (Part B): ④ _____/_____/_____
(month/date/year)

5. Zip Code: _____ City: _____

6. County: _____ State: _____

7. Address: _____

8. Phone (_____)_____

9. List two pharmacies

_____ _____

Return worksheet 1 week prior to your appointment.

Harvey County Extension
Attn: SHICK Program
P.O. Box 583
ZIP Code 67114
Newton, KS
Phone: (316)284-6930

Optional *(You may qualify for help paying for your prescription drugs)*

10. What best describes your income (per year)?

Single/widowed/divorced/live apart from spouse and make ☐ less than $17,235 ☐ more than $17,235
Married and make ☐ less than $23,265 per year ☐ more than $23,265 per year

11. What best describes your liquid assets? Total value of savings, investments, and real state (not your primary home, vehicles, or burial plots).

Single/widowed/divorced/live apart from spouse and: ☐ less than $13,300 ☐ greater than $13,300
Married and ☐ less than $26,580 ☐ greater than $26,580

12. Race/ethnicity – check all that apply

☐ Hispanic, Latino, or Spanish
☐ White, Non-Hispanic Origin
☐ Black, African-American
☐ American. Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Vietnamese
☐ Korean
☐ Native American
☐ Other Asian
☐ Other Race/Ethnicity

OVER ➔

13. Which prescription drugs do you currently take? (Please also list the dosage, how often you take it per month and your monthly cost). **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

DRUG NAME	DOSAGE	30-DAY QUANTITY (or estimation)	MONTHLY COST

SHICK Disclaimer

SHICK Counselor Name: _____

I have reviewed a minimum of three Medicare Part D Prescription Drug Plans and have chosen the following plan: _____. I gave the SHICK counselor listed above my authorization to enroll me in the above plan using the information I have provided. I confirm that all information provided is truthful and accurate and I hereby release the SHICK counselor, the SHICK organization ad the State of Kansas from any liability whatsoever, known or unknown, related or pertaining my Medicare Part D 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 plan until the next open enrollment period which will be October 15, 2016 to December 7, 2016.

I also understand that the costs and covered medication quoted on the plan I've chosen may be subject to change.

Signature: _____ Printed Name: _____

Date: _____ Drug List ID: __ __ __ __ __ __ __ __ __ __ Password Date: _____

Office use only: