Medicare Part D **Date Received:** ____________

Prescription Drug Plan Finder Tool

Call your local SHIIP office at (828) 758-2883

___I have a Federal Employees Health Benefit Plan/TRICARE for Life/Veterans' Administration.

___I have a NC State Employee Health Plan.

___I am currently receiving Retiree Coverage from a current or former employer.

STOP **IF YOU CHECK ANY OF THE THREE ITEMS ABOVE, please call the Caldwell Senior Center at 758-2883 before continuing.**

Name: ____ **Date of Birth**: ___________________

(Please provide your name as it appears on your Medicare card.) Male ___ Female ___

What is YOUR Medicare number? ________________________________

What is YOUR effective date for Medicare Part A? ____________________

What is YOUR effective date for Medicare Part B? ____________________

****If you have ever had a MyMedicare Account, you will need to provide your login and password. Thank you.**

Address: ____ Race: _________________

(Please provide the address and zip code you have on file with Medicare.)

City: ____ **State:** _________ **Zip:** ______________

If PO Box, what is your physical address? ____

Phone: ____________________ **County:** _______________ **Email:** _______________________________

Do you live in NC year round? ___ Yes ___ No **What is your primary language (if not English)?**____________

How did you learn about SHIIP? ____

Are you interested in learning about Medicare prescription drug coverage available through:

___ Medicare Prescription Drug Plans ___ Medicare Advantage Plans

I receive full Medicaid: (circle) **YES NO /// Medicaid Pays Medicare premium:** (circle) **YES NO**

Are you interested in learning more about Medicare Supplements? (circle) **YES NO**

"EXTRA HELP SUBSIDY" (Helps pay for drug plan premium & drug costs)

To ***qualify for Extra Help***, You MUST qualify in **BOTH: Income & Assets.**

Income limit: Individual $1,595/Couple $2,155 per month. *Asset limits*: Individual $13,110/Couple $26,160

WHAT IS YOUR MONTHLY INCOME? ______________: (Use amount BEFORE they deduct anything, NOT what you receive. I**nclude** social security, pensions, and VA benefits, Etc.)

WHAT IS YOUR SPOUSE'S MONTHLY INCOME? ________________:

Spouse's Full Name: ________________________________ **Spouse's Birthdate:** ___________________

I prefer to have my prescriptions filled at these pharmacies: ____

Please check all that apply: ___ I live in a Long-Term Care Facility. ___ I prefer to use a mail order pharmacy.

I give my consent for a SHIIP volunteer counselor to set up a MyMedicare Account and/or access to my information in the Medicare Plan Finder. I understand that I can change my password at any time after receiving assistance.

_______________________________________ DATE: _____________

SIGNATURE

OFFICE USE ONLY:

WORKER: ______________________

Please provide us with information about your prescriptions. NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach. If not, please complete the chart below.

NAME OF DRUG	BRAND NAME ONLY?	STRENGTH	QUANTITY PER MONTH
Example: Lipitor	*Ex.: Yes*	*Example: 10 mg.*	*Example: 60*
Example: Humalog INJ	*Ex.: No*	*Example: 100/ML*	*Example: one (3ML) vial*
List diabetic and nebulizer Medications ONLY— NOT supplies (strips, needles, etc.)	******	**********************	**************************

Once completed, **please take this form to the Caldwell Senior Center drop box**
or mail to:
Caldwell Senior Center
PO Box 933
Lenoir, NC 28645

I prefer that you Contact the following person to set up my appointment:

Name: ____

Relationship: ___________________________________

Phone Number: _________________________________

After receiving this information from you, we will do the research <u>& call you to set up an appointment time</u>.