SHIP State Health Insurance Assistance Program — Navigating Medicare

SARCOA Area Agency on Aging

SMP Senior Medicare Patrol — Preventing Medicare Fraud

**Please return this completed form to SARCOA**

1075 S. Brannon Stand Road, Dothan, AL 36305
Fax: 334-671-3651
Email: sarcoaship@gmail.com

| Exact Name on Medicare Card: | Sex: ___Female __ Male | Date of Birth: | Where Were You Born? County: _____ U.S. Citizen: Y N City: _____ State: _____ |
|---|---|---|---|
| Medicare Number: | Part A Start Date | Part B Start Date | |
| Social Security Number: | Marital Status (circle one): Single Married Widowed Divorced Separated | Race: | Hispanic? / Total # in Household |
| Physical Address: | City: | State: | Zip Code: |
| Mailing Address (if different from above): | City: | State: | Zip Code: |
| County You Reside In: | Primary Telephone Number: | Secondary Telephone Number: | |
| Email Address: | Do You Reside With a Spouse? Yes No | VA Benefits: Yes No | Total Household Income: $_____ |

**Are you currently receiving any of the following?**
**(check all that apply):**

_____ Extra Help/ LIS _____ SLMB/ QI _____ QMB
_____ SSI (Supplemental Security Income)
_____ Medicaid Waiver Program
_____ SS (Social Security Retirement)
_____SSDI (Social Security Disability Insurance)

Spouse/ Former Spouse Full Name: _____

Spouse/ Former Spouse DOB:_____

Spouse/ Former Spouse Soc Sec #: _____

**I am currently enrolled in the following (check all that apply):**

____Original Medicare _____ Medicare Advantage _____ Medicare Supplement _____ Medicare Prescription Drug

____Employee Plan _____ Retiree Plan _____ Federal Retiree _____Railroad Retiree _____ State or Public Ed Retiree

____Veterans Administration _____TRICARE/ Champ VA

**Please read the following statements and initial each and sign/ date at the bottom:**

_____ I understand that I have requested insurance counseling services through the SHIP.

_____ I understand that I am solely responsible for the final selection and enrollment into a Medicare plan, and I hereby waive and release my SHIP counselor, SARCOA and all of its employees and volunteers, as well as the Alabama Department of Senior Services (ADSS) from any and all liability incurred in my final selection and enrollment into a Medicare plan.

_____ I understand that my SHIP counselor, SARCOA and all of its employees and volunteers, and ADSS expressly disclaim any guaranty or warranty of the Medicare plan I select.

**Client Signature:** _____ **Date:** _____

**DON'T FORGET TO COMPLETE THE BACK OF THIS FORM**

## Please list each of your prescriptions in the columns below

| **Name of Prescription** (Exactly as it appears on the container) | **Strength of Medication** | **Type of Medication** (ex: TAB, CAP, cream, ointment, liquid…) | **How often do you take this medication?** (ex: 1x day; 2x day; 1x wk, etc) | **How often do you get this medication refilled?** (ex: 30 days; 90 days, etc.) |
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Preferred Pharmacy _____

Alternate Pharmacy _____

Do you use Mail Order? _____Yes _____ No

Please list any prescriptions NOT covered by your current prescription drug insurance plan:

_____ _____

_____ _____

**Please Read & Initial One :**

_____I authorize the SHIP program and/ or its counselors to enroll me in the most cost-effective plan.

_____I prefer to have the comparison mailed to me so that I may review it and enroll myself

**Office Use Only:**

**MyMedicare.gov User ID:** _____ **Password**:_____ **Security Question/ Answer:** _____

**Current Plan Enrolled in:** _____ **New Plan Enrolled in:** _____

**Total Out of Pocket Cost:** _____ **Total Out of Pocket Cost:** _____ **Savings:** _____

**MSP Application Completed:** _____Yes ___NO **Was the MSP Application submitted by the SHIP Counselor?** _____Yes ____ No

**SHIP Counselor Name:** _____**Date Contact Made:** _____