





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:FemaleMale | | | Has SARCOA SHIP helped you in the past? | | | | |
|--|--|---------------------------|-------------------------|---|---|---------------|---|--------------|--|
| Medicare Number: | Part A St | tart Date | Part B | Start Date | Yes | SN | 0U | Insure | |
| Social Security Number: | l Security Number: Marital Status (circle Single Married Widowed Divor | | | | 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 Tel | Primary Telephone Number: | | | Secondary Telephone 1 | | | Number: | |
| Email Address: | Do You Reside with a Yes No | | | Spouse? | VA Benefits: Yes No | | Gross Household Income: Yours \$ Spouse/other \$ | | |
| Are you currently receiving any of the following? (check all that apply): Extra Help/ LISSLMB/ QIQMBSSI (Supplemental Security Income)Medicaid Waiver ProgramSS (Social Security Retirement)SDI (Social Security Disability Insurance) | | | МВ | How did you hear about us (SARCOA SHIP)? AdvertisementSocial MediaSocial SecurityMedicaid OfficeMedicareSenior Center | | | | | |
| <u>I</u> :Original MedicareEmployee Plan | Retiree Plan | re Advantage | e Med | dicare Supplem | entd Retiree | Medicare Pres | _ | | |
| Please read the | e following s | statement | ts and init | ial each an | <mark>d sign/ d</mark> a | ate at the b | ottom: | | |
| I understand tha | • | | | - | | _ | | dicare plan. | |
| and I hereby wa volunteers, as w incurred in my | nive and released as the Al | ase my SI abama De | HIP counse epartment | elor, SARC of Senior S | OA and a ervices (A | ll of its em | ployees a | and | |
| I understand that expressly discla | | | | | | | lunteers, | , and ADSS | |
| Client Signature: | Ž | • | • | | - | Oate: | | | |
| | | | | | | | | | |

DON'T FORGET TO COMPLETE THE BACK OF THIS FORM

Please list each of your prescriptions in the columns below Strength of Type of Medication How often do you How often do you get Name of Prescription this medication refilled? (ex: TAB, CAP, cream, take this Medication (Exactly as it appears on the ointment, liquid...) (ex: 30 days; 90 days, etc.) medication? container) (ex: 1x day; 2x day; 1x wk, etc) Preferred Pharmacy _____ Please Read & Initial One: Alternate Pharmacy _____ I authorize the SHIP program and/ or its counselors to enroll me in the most Do you use Mail Order? _____Yes _____No cost-effective plan. Please list any prescriptions NOT covered by your current I prefer to have the comparison mailed prescription drug insurance plan: 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: | DID NOT CHANGE PLANS: (initials) |
| Total Out of Pocket Cost: | |
| New Plan Enrolled in: | |
| Total Out of Pocket Cost: | Savings: |
| Applied for Extra Help (online with SSA)YesNo | |
| MSP Application Completed:YesNO | |
| Was the MSP Application submitted by the SHIP Counselor? Yes | es No |
| SHIP Counselor Name: | Date Contact Made: |
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