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
Telephone: 334-793-6843 Fax: 334-699-1014
Email: joy.riddle@sarcoa.org

Exact Name on Medicare Card:	Sex: ___Female __ Male	Date of Birth:	Has SARCOA SHIP helped you in the past? _____ Yes _____NO _____Unsure
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:

Are you a U.S. citizen? Yes or No County Born? City Born? State Born?	Do You Reside with a Spouse? Yes No	VA Benefits: Yes No	Gross Household Income: Yours $_____ Spouse/other $_____

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)

How did you hear about us (SARCOA SHIP)?

_____Advertisement
_____Social Media
_____Social Security
_____Medicaid Office
_____Medicare
_____Senior Center

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.)

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: _____

Notes: