# SHIIP Client Information Form

***Please provide the following information for our records.***

**What is your name on your <u>Medicare card</u> and address on record with Medicare?**

First Name M.I. Last Name Jr/Sr/I/II

Client Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ Mobile Phone _____

Email Address _____ County _____

**What is your Medicare Claim Number on your Medicare card?**

| | | | | - | | | | - | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

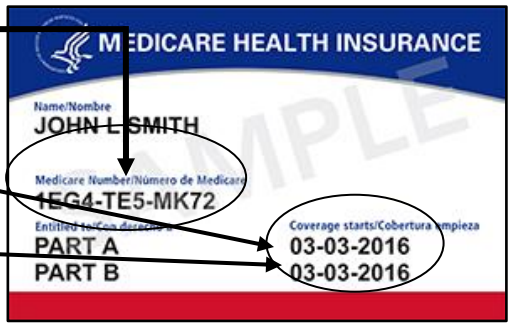
**What is your Medicare effective date(s)?**

Part A--Month Day Year

| | | - | | | - | | | | |
|---|---|---|---|---|---|---|---|---|---|

Part B--Month Day Year

| | | - | | | - | | | | |
|---|---|---|---|---|---|---|---|---|---|




## *Representative Information (Son, Daughter, Friend or POA)*

Representative's Name _____

Rep Address _____

City _____ State _____ Zip Code _____

Phone _____ Email Address _____

## *Client Demographics*

**Date of Birth** _____ / _____ / _____ **Gender:** M _____ F _____

**Primary Language** English _____ Other _____

**Is your income above or below the following amounts:** Above _____ Below _____
Individual--$19,380/yr ($1,615/mo) or Couple--$26,100/yr ($2,175/mo)

**Are assets above or below the following amounts:** Above _____ Below _____
Individual--$14,610 or Couple--$29,160

**On Medicare Due to a Disability (under age 65):** Yes _____ No _____

**SHIIP Use Only:** Premium Payment SSA ☐ Direct Bill ☐

Contact Person: _____ Phone _____

User Name: _____ Password: _____ Security: _____

**Ethnicity/Race:** Please select one of the following.

_____ Hispanic, Latino, or Spanish Origin
_____ White, Not of Hispanic Origin
_____ Black, African-American
_____ American Indian or Alaska Native
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ Not Collected

***How did you hear about SHIIP?***

_____ Agency (e.g. AAA)
_____ Congressional Office
_____ DHS-State Medicaid Agency
_____ Friend/Relative
_____ Health/Drug Plan
_____ Insurance agent/company
_____ Mailings/Brochures/Posters/Newsletters
_____ Media (newspaper, TV, radio, ad)
_____ Medical Provider
_____ Medicare (e.g. 800#, pub, mailing)
_____ Pharmacy
_____ Presentations/Fairs
_____ Prior Contact
_____ SHIIP Website
_____ SSA
_____ Other
_____ Not Collected

## Complete this information only if you need a Medicare Part D Comparison

**What is your current drug coverage? Check any that apply.**

☐ Medicare Part D Plan
Plan Name _____

☐ Medicare Advantage Plan
Plan Name _____

☐ TRICARE for Life
☐ VA benefits
☐ None
☐ Employer/Retiree plan
☐ Federal Employee Health Benefit Plan
☐ Other _____

**How would you like to get your Medicare drug benefits? Please provide a comparison of (check one):**

☐ Medicare drug plans only ☐ Medicare Advantage Plans only ☐ Both

**Do you currently receive any of the following benefits?**

☐ Medicaid (Title 19 - MEPD, SSI, Elderly Waiver, Medically Needy Spend-down, Nursing Home)
☐ Help paying your Medicare Part B premium (QMB, SLMB, QI)
☐ Extra Help with your Medicare drug costs
☐ Pay $1.25 for generics and $3.80 for brand name drugs
☐ Pay $3.40 for generics and $8.50 for brand name drugs

**What pharmacy do you prefer? You may list two.**

| Name of Pharmacy | Address and City | Phone Number |
|---|---|---|
| | | |
| Name of Pharmacy | Address and City | Phone Number |