



SHIIP Client Information Form

Please provide the following information for our records.

What is your name on your Medicare card 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 _____

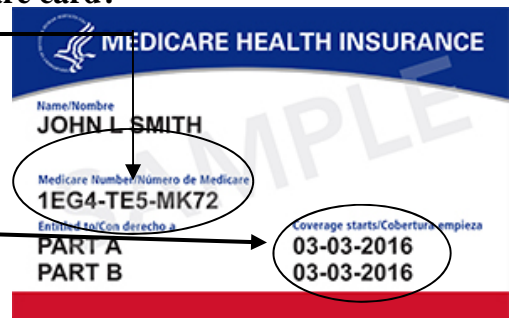
Email _____ County _____
Address _____

What is your Medicare Claim Number on your Medicare card?

12 empty boxes for Medicare claim number

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--\$18,450/yr (\$1,538/mo) or Couple--\$24,930/yr (\$2,078/mo)

Are assets above or below the following amounts: Above _____ Below _____
Individual--\$14,100 or Couple--\$28,150

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

SHIIP Use Only: Premium Payment SSA Direct Bill
Contact Person: _____ Phone _____
Drug List ID _____ Zip Code _____ Password Date _____

Ethnicity/Race: Please select one of the following.

- | | |
|--|---|
| <input type="checkbox"/> Hispanic, Latino, or Spanish Origin | <input type="checkbox"/> Korean |
| <input type="checkbox"/> White, Not of Hispanic Origin | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Black, African-American | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other Asian |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Other _____ |

How did you hear about SHIP? _____

- | | |
|--|---|
| <input type="checkbox"/> Medicare (e.g. 800#, Publication, Mailing) | <input type="checkbox"/> Medical Provider |
| <input type="checkbox"/> Presentations or Fairs | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Mailings, Brochures, Posters or Newsletters | <input type="checkbox"/> Insurance Agency or Provider |
| <input type="checkbox"/> Agency (e.g. AAA, Social Security Administration) | <input type="checkbox"/> Prior Contact |
| <input type="checkbox"/> Friend or Relative | <input type="checkbox"/> SHIP Website |
| <input type="checkbox"/> Media (Newspaper, TV, Radio or Other Ad) | <input type="checkbox"/> Other _____ |

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 _____
- | | |
|---|---|
| <input type="checkbox"/> TRICARE for Life | <input type="checkbox"/> Employer/Retiree plan |
| <input type="checkbox"/> VA benefits | <input type="checkbox"/> Federal Employee Health Benefit Plan |
| <input type="checkbox"/> None | <input type="checkbox"/> 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 \$3.70 for brand name drugs
- Pay \$3.35 for generics and \$8.35 for brand name drugs

What pharmacy do you prefer? You may list two.

Name of Pharmacy	Address and City	Phone Number