2021 ECKAAA-K-State Research & Extension – Johnson County
SHICK – Senior Health Insurance Counseling for Kansas
Medicare Part D Worksheet

Open Enrollment October 15 through December 7, 2020

Name

Street/Mailing Address

City **State** Zip **C**ode Phone

County **Race** **Birthday**

Email

Medicare # Part A Eff Date Part B Eff Date

Which are you currently enrolled in: Original Medicare w/Medigap plan? Medicare Advantage plan with drugs?

Are you requesting a comparison of Medicare Advantage plans for w/drug coverage for 2021? Yes No

Release of Information:

I give the ECKAAA--K-State Research & Extension – Johnson County SHICK Counselor authorization to use my personal/Medicare/Medigap information and/or my "myMedicare.gov" logon and password information:

- To generate my best three drug or Medicare Advantage plan comparisons from the information provided on this worksheet;
- To assist in enrollment in the plan of my choosing based on the comparison information provided.
- To assist me with any grievances, complaints or questions I have regarding Medicare or other health insurance coverage, benefits determination and billing by accessing coverage determination or billing records as necessary to assist with my issue(s). The ECKAAA-KSRE SHICK Counselor may need to discuss my health insurance and obtain coverage and billing information from Medicare, Social Security, one of the MCO companies for KS Medicaid, past/present employer, my prescription drug plan, my physician, pharmacy and/or hospital to discern available options for me and to resolve any issues/needs I may have with coverage and/or billing.

I confirm that all information I provide is truthful and accurate and I hereby release the KSRE-SHICK Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining to my Medicare Part D or Medicare Advantage enrollment herein. I also acknowledge that information discussed with the Counselor cannot be relied upon nor construed as legal advice. I understand that I may not change my drug or Medicare Advantage plan until the next open enrollment period. I understand the costs and covered medications quoted on the plan I have chosen may be subject to change.

ECKAAA-KSRE SHICK services are free of charge. (Donations to offset program costs are accepted.) The ECKAAA-KSRE SHICK Counselor will provide me a copy of this consent form if I request. The original will be kept in my SHICK client file, which is stored in a secure manner. I may cancel my consent at any time and will notify SHICK if I choose to do so. I understand that once I have signed this consent form, I can expect my ECKAAA-KSRE SHICK Counselor to help me without asking me to sign another consent form.

Signature: Printed Name:

Date:

*My*Medicare Account Login Information: (PLEASE PRINT)

Username: Password:

Release to have A MyMedicare account set up:
If you have not set up this account, the ECKAAA-KSRE SHICK Counselor can do so for you if you sign and complete the information below. This information will be given to you and a copy will be maintained in your SHICK client folder.

Signature: Printed Name:

Date:

Username: Password:

Are you eligible for Extra Help according to the guidelines below? Yes No

If you received a letter from the Social Security Administration about Extra Help, please attach it.

Single:	Income below $1615 per month/Resources below $14,610
Married (living with spouse):	Income below $2174 per month/Resources below $29,160

***** If you take a generic medication, please write down that name rather than listing the brand name.**

	Complete Drug Name	Will you take generic if available?	Form (Capsule, Tablet, Spray, Injection, etc.)	Dosage/ Strength	Pills: # taken per day Other forms: # vials/ pens/ tubes used per month
1.					Pills # Other #
2.					Pills # Other #
3.					Pills # Other #
4.					Pills # Other #
5.					Pills # Other #
6.					Pills # Other #
7.					Pills # Other #
8.					Pills # Other #
9.					Pills # Other #
10.					Pills # Other #
11.					Pills # Other #
12.					Pills # Other #
13.					Pills # Other #
14.					Pills # Other #

If you take more than 13 medications, please list them on an attached page.

Name and address of your preferred retail pharmacy:____

RETURN THIS COMPLETED FORM TO:

Denise Dias
K-State Research & Extension Johnson County
11811 S. Sunset Dr, Suite 1500
Olathe, KS 66061
denise.dias@jocogov.org

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