2017 For Office Use Only:

Drug List ID:_____ Password Date:_____

MEDICARE PRESCRIPTION DRUG COVERAGE WORKSHEET

NAME:_____

ADDRESS:_____

CITY: _____ ZIP:_____

PHONE:_____ COUNTY:_____ RACE:_____

EMAIL: _____

MEDICARE ID NUMBER:_____ BIRTH DATE:_____

EFFECTIVE DATE FOR PART A_____ FOR PART B_____

Contact information if you are handling this worksheet for someone else:
Name_____ Phone:_____

Address:_____

Email:_____

1. Do you currently have a Part D Prescription Drug Plan? Yes_____ No_____
If yes, what company?_____ what Plan?_____

2. Is any, or all, of your Part D premium paid by the government? YES___ NO____ Don't know____
("Extra help" means the government pays all/part of premium and copays
If you received a letter about your Extra Help please attach it.

Are you eligible for extra help but not currently receiving it (see guidelines below)? Yes_____ No_____

Annual income and resource limits to qualify for Extra Help

Single- income less than $1,485/month & resources less than $13,640
Married (living w/spouse)- income less than $2003/month & resources less than $27,250
Numbers based on information at www.medicare.gov and www.socialsecurity.gov, Aug 2016

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–HOW DO I GET HELP DECIDING WHAT PRESCRIPTION DRUG I NEED?

1. **Complete this worksheet and return it to Sallee Hess, CF CO Health Dept., 110 S 6th, Burlington**
2. **You will be mailed a comparison of the top 3 plans.**
3. **If you would still like help or require further assistance, make an appointment with a staff member by calling 620-364-8631**

Please list all the prescription medications you take on the back

Donations are appreciated to help offset the costs of our Senior Health Insurance Counseling for Kansas (SHICK) program and are tax deductible. Checks may be made payable to ECKAAA. Thank you for your generosity!

PLEASE LIST PHARMACIES IN ORDER OF PREFERENCE WITH ADDRESS'S

1>

2.

If you take a generic medication, please use the generic name rather than listing the brand name.

Please Print		Drug List ID:
		Password Date:

	Complete Drug Name	**Are you willing to take a generic?**	**Capsule or Tablet**	**Dosage/ Strength**	**# of Pills Taken Per Day (Example: 1 tab 3 times per day 1 tab per wk or month)**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Comments:_____

YOU WILL BE EMAILED OR MAILED PLAN INFORMATION ON THE TOP 3 PLANS FROM THE MEDICARE WEBSITE. CALL FOR AN APPOINTMENT UPON RECEIVING IT IF YOU NEED FURTHER ASSISTANCE. 620-364-8631

RETURN THIS FORM TO:
Sallee Hess, CF County Health Dept., 110 S 6th, Burlington, KS 66839