K-State Research & Extension, Marais des Cygnes District – Paola & Mound City Offices

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Form must be completed and returned to the Extension Office before assistance can be provided. Once we receive your form, we will contact you with more information.

MEDICARE DRUG PLAN WORKSHEET – Items marked with asterisk (*) indicate required fields.

Beneficiary & Representative Name and Contact Information*

Name: **Are you new to Medicare? YES NO**

Street Address:____

City:____________ **County:** ____________ **State:** ____________ **ZIP:** ____________

Date of Birth:____________ Age Group: 64 or Younger 65-74 75-84 85 or Older

Phone:____________ **Email:** ____________

Personal Representative:____________ **Phone:**____________ **Email:** ____________

Gender: M F Other

Beneficiary Race * (multiple selections allowed):

American Indian or Alaska Native Asian;
Black or African American Hispanic or Latino
Native Hawaiian or Other Pacific Islander
White Other

How Did You Learn About SHIP * (select one):

Friend or Relative Previous Contact
Presentation 1-800 Medicare Other

Have You or a Family Member Served in the Military? Yes No

Do you receive Social Security 'Extra Help? **If you received a letter about Extra Help please attach it.**

Yes No

Receiving or Applying for Social Security Disability or Medicare Disability * (select only one):

Yes No

Extra help may be available - if your income & resources are within the following. From www.medicare.gov 2023

Extra Help Income/Resource Guidelines	Income Less Than	Resources Less Than
Single	$1,823/mo	$16,600
Married (living with spouse)	$2,465/mo	$33,240

Medicare Number:____________

Effective Date: Part A: ____________ Part B:____________

Do you have a Medicare Advantage Plan? YES NO

Current Insurance: ____________

Current Drug Plan: ____________

MyMedicare User Name:____________

MyMedicare Password:____________

MyMedicare Question:____________

I give the SHICK Counselor authorization to use my "myMedicare.gov" logon and password to generate drug plan comparisons from the information provided on this worksheet and/or to assist in enrollment in the plan of my choosing based on the comparison provided. I confirm that all information provided is truthful and accurate and I hereby release the Counselor, the SHICK organization and the State of Kansas from any liability whatsoever, known or unknown, related or pertaining to my Medicare Part D enrollment. I 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 plan until the next open enrollment period, October 15, 2024 to December 7, 2024. I understand that the costs and covered medications quoted on the plan chosen may change.

Signature:____________________ Date:____________________

Please complete pharmacy information.
Pharmacy choice will have an impact on your overall plan options.

Pharmacy Preferences		Primary Concerns – Check All that Apply
1st Choice		All Drugs Covered
2nd Choice		Drug Deductible – none (Level Co-pays = higher premium)
Mail Order	Yes No	Lowest Total Premium + Drug Costs

Which drugs do you currently take? (List the dosage and how often you take it per month.)
PRINT CLEARLY or provide a current LIST of current prescriptions (not all purchases).
Do not list over the counter drugs.

Name of Prescription Drug	Dosage (#mg/pill)	Frequency 30-Day Quantity (1 pill/day would be 30)
For Example: Atorvastatin	10mg	30