OMB No. 0938-0850

State Health Insurance Assistance Program (SHIP) Client Contact Form (_ _)

Counselor Name:

Counseling Location Zip Code:

__ __ __ __ __

Type of Client/Assistance Requested by: (check all that apply)

- ❑ Beneficiary (self)
- ❑ Couple
- ❑ Caregiver (family member, conservator)
- ❑ Agency

How Did Client Learn About the SHIP: (check one)

- ❑ CMS (1-800-Medicare, www.Medicare.gov, Medicare & You, CMS mailing)
- ❑ Presentations/Fairs
- ❑ State-specific mailings/brochures/ posters
- ❑ Agency (senior org, disability org, Social Security)
- ❑ Friend/Relative
- ❑ Media (PSA, ad, newspaper, radio, etc.)
- ❑ Other: _____
- ❑ Not Collected

Date of Initial Contact:

__ __ / __ __ / __ __ __ __
month / day / year

Type of Contact:

- ❑ Quick call (<10 min)
- ❑ Telephone
- ❑ In-Person (site)
- ❑ In-Person (home visit)
- ❑ E-mail/fax/postal mail

Time Spent:

_____ **hours** _____ **minutes**

Date if Multiple Contact:

__ __ / __ __ / __ __ __ __
month / day / year

Type of Contact:

- ❑ Quick call (<10 min)
- ❑ Telephone
- ❑ In-Person (site)
- ❑ In-Person (home visit)
- ❑ E-mail/fax/postal mail

Time Spent:

_____ **hours** _____ **minutes**

SECTION 1 – BENEFICIARY INFORMATION

Beneficiary Name:

_____ _____
First Last

Beneficiary Zip Code:

__ __ __ __ __

Representative Name (if applicable):

_____ _____
First Last

Beneficiary Telephone #:

(__ __ __) __ __ __ - __ __ __ __

SECTION 2 – BENEFICIARY DEMOGRAPHICS

Is this his/her first contact with a SHIP since April 1? ☐ **Yes** ☐ **No**
(If Yes, Complete this section. If No, Skip to Section 3)

Age:

Date of Birth: __ __ / __ __ / __ __ __ __ **OR**
month / day / year

- ❑ Under 65 years
- ❑ 65 – 74
- ❑ 75 – 84
- ❑ 85 or older
- ❑ Not Collected

Monthly Income:

- ❑ Below 150% of FPL
- ❑ At or greater than 150% of FPL
- ❑ Not Collected

$_____

Race/Ethnicity:

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White, Not of Hispanic origin
- ❑ Other
- ❑ Not Collected

Gender:

- ❑ Female
- ❑ Male
- ❑ Not Collected

Disabled:

- ❑ Yes
- ❑ No
- ❑ Not Collected

SECTION 3 – TOPICS DISCUSSED (check all that apply)

Prescription Assistance:

Medicare Prescription Drug Coverage (PDP/MA-PD):

- ❑ Plan eligibility, benefit comparisons
- ❑ Low-income assistance - eligibility, benefit comparisons
- ❑ Enrollment / application assistance
- ❑ Claims / billing
- ❑ Appeals/quality of care/complaints

Other Sources of Prescription Drug Coverage/Assistance:

- ❑ Medicare-Approved Drug Discount Card
- ❑ State Pharmacy Assistance Program
- ❑ Union/Employer plan
- ❑ Manufacturer's Assistance Program
- ❑ Discount plans
- ❑ Other: _____

Medicare (Parts A and B):

- ❑ Enrollment, eligibility, benefits
- ❑ Claims/billing
- ❑ Appeals/quality of care/complaints

Medicare Health Plans (HMOs, PPOs, PFFS, Special Needs Plans):

- ❑ Enrollment, disenrollment, eligibility, comparisons
- ❑ Plan or benefit changes/non-renewals
- ❑ Claims/billing
- ❑ Appeals/quality of care/complaints

Medicaid (enrollment, eligibility, benefits):

- ❑ QMB/SLMB/QI
- ❑ Other Medicaid

Medigap/Supplement/SELECT:

- ❑ Enrollment, eligibility, comparisons
- ❑ Change coverage
- ❑ Claims/appeals

Other:

- ❑ Long-Term Care
- ❑ Fraud and Abuse
- ❑ Military Health Benefits
- ❑ Employer Health Plan or Federal Employee Health Benefits Program
- ❑ Customer Service issues/complaints
- ❑ Other: _____