

State Health Insurance Assistance Program (SHIP) Public and Media Activity Form (_ _)

Instructions: This form is for all SHIP Public and Media Activities. Use one form per activity, which can include in-person presentations, booths/exhibits, media or internet activities. Definitions of each type of activity are provided in the accompanying instructions.

SECTION 1 - TYPE OF ACTIVITY (Check only one type of activity A-G)

<input type="checkbox"/> A. Interactive presentation to public ♦ In-Person ♦ Video teleconference or satellite broadcast Estimated # of attendees: _____ Estimated # of people enrolled (If any): _____	<input type="checkbox"/> D. Web-site event ♦ Web conference/forum ♦ Interactive chatroom Estimated # of people potentially reached: _____
<input type="checkbox"/> B. Booth/exhibit at health/senior fair, etc. Estimated # of people potentially reached: _____ Estimated # of people enrolled (If any): _____	<input type="checkbox"/> E. TV/cable show (not a PSA or ad) Estimated # of people potentially reached: _____ # times this show re-aired (if known) _____
<input type="checkbox"/> C. Radio show (not a PSA or ad) Estimated # of people potentially reached: _____ # times this show re-aired (if known) _____	<input type="checkbox"/> F. Enrollment Event Estimated # of people enrolled: _____
	<input type="checkbox"/> G. Other: _____ (e.g. PSAs, targeted informational mailing, newspaper/newsletter articles) Estimated # of people potentially reached: _____ # times this PSA re-aired/re-printed/etc. (if known) _____

SECTION 2 - ACTIVITY INFORMATION (Please provide the following information if applicable.)

Date of activity: ____ / ____ / ____ month / day / year Time of activity: Start ____ Stop ____ If multiple dates: ____ / ____ / ____ through ____ / ____ / ____ Total length of activity across all dates: ____ hrs (round to nearest hour)	Event or group name: _____ Location of event: Address: _____ City, State, Zip: _____ County: _____ Name(s) of Presenter(s): _____
Contact Name: _____ Contact Phone: _____	Type of Presenter(s): <input type="checkbox"/> SHIP Staff/coordinator/sponsor <input type="checkbox"/> SHIP Counselor/volunteer <input type="checkbox"/> Other: _____

SECTION 3 - TOPIC FOCUS (Check all that apply)

<input type="checkbox"/> Medicare (Parts A and B) <input type="checkbox"/> Non-renewal situation <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Medigap/Medicare Supplements <input type="checkbox"/> Fraud & Abuse <input type="checkbox"/> Medicare Prescription Drug Coverage (PDP/MA-PD)	<input type="checkbox"/> Other Prescription Drug Coverage/Assistance <input type="checkbox"/> Medicare Health Plans <input type="checkbox"/> QMB/SLMB/QI <input type="checkbox"/> Other Medicaid <input type="checkbox"/> General SHIP program information <input type="checkbox"/> Other (specific health topics--ESRD, diabetes): _____
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SECTION 4 - TARGET AUDIENCE (Check all that apply)

<input type="checkbox"/> Medicare beneficiaries and/or pre-enrollees <input type="checkbox"/> Family members/caregivers of Medicare benes. <input type="checkbox"/> Low-income <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White, Not of Hispanic origin <input type="checkbox"/> Disabled <input type="checkbox"/> Rural <input type="checkbox"/> Other (please describe, such as professionals): _____
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