

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) <ul style="list-style-type: none"> <input type="checkbox"/> Beneficiary (self) <input type="checkbox"/> Couple <input type="checkbox"/> Caregiver (family member, conservator) <input type="checkbox"/> Agency 	How Did Client Learn About the SHIP: (check one) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> CMS (1-800-Medicare, www.Medicare.gov, Medicare & You, CMS mailing) </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Agency (senior org, disability org, Social Security) </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Presentations/Fairs </td> <td style="vertical-align: top;"> <input type="checkbox"/> Friend/Relative </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> State-specific mailings/brochures/posters </td> <td style="vertical-align: top;"> <input type="checkbox"/> Media (PSA, ad, newspaper, radio, etc.) </td> </tr> <tr> <td></td> <td style="vertical-align: top;"> <input type="checkbox"/> Other: _____ </td> </tr> <tr> <td></td> <td style="vertical-align: top;"> <input type="checkbox"/> Not Collected </td> </tr> </table>	<input type="checkbox"/> CMS (1-800-Medicare, www.Medicare.gov, Medicare & You, CMS mailing)	<input type="checkbox"/> Agency (senior org, disability org, Social Security)	<input type="checkbox"/> Presentations/Fairs	<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> State-specific mailings/brochures/posters	<input type="checkbox"/> Media (PSA, ad, newspaper, radio, etc.)		<input type="checkbox"/> Other: _____		<input type="checkbox"/> Not Collected
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	<input type="checkbox"/> Other: _____											
	<input type="checkbox"/> Not Collected											

Date of Initial Contact: ____ / ____ / ____ month / day / year	Type of Contact: <ul style="list-style-type: none"> <input type="checkbox"/> Quick call (<10 min) <input type="checkbox"/> Telephone <input type="checkbox"/> In-Person (site) <input type="checkbox"/> In-Person (home visit) <input type="checkbox"/> E-mail/fax/postal mail 	Time Spent: _____ hours _____ minutes
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Date if Multiple Contact: ____ / ____ / ____ month / day / year	Type of Contact: <ul style="list-style-type: none"> <input type="checkbox"/> Quick call (<10 min) <input type="checkbox"/> Telephone <input type="checkbox"/> In-Person (site) <input type="checkbox"/> In-Person (home visit) <input type="checkbox"/> E-mail/fax/postal mail 	Time Spent: _____ hours _____ minutes
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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 <ul style="list-style-type: none"> <input type="checkbox"/> Under 65 years <input type="checkbox"/> 75 – 84 <input type="checkbox"/> Not Collected <input type="checkbox"/> 65 – 74 <input type="checkbox"/> 85 or older 	Monthly Income: <ul style="list-style-type: none"> <input type="checkbox"/> Below 150% of FPL <input type="checkbox"/> At or greater than 150% of FPL <input type="checkbox"/> Not Collected \$ _____	Race/Ethnicity: <ul style="list-style-type: none"> <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"/> Other <input type="checkbox"/> Not Collected
Gender: <ul style="list-style-type: none"> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Not Collected 	Disabled: <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Collected 	

SECTION 3 – TOPICS DISCUSSED (check all that apply)

Prescription Assistance: <ul style="list-style-type: none"> Medicare Prescription Drug Coverage (PDP/MA-PD): <ul style="list-style-type: none"> <input type="checkbox"/> Plan eligibility, benefit comparisons <input type="checkbox"/> Low-income assistance - eligibility, benefit comparisons <input type="checkbox"/> Enrollment / application assistance <input type="checkbox"/> Claims / billing <input type="checkbox"/> Appeals/quality of care/complaints Other Sources of Prescription Drug Coverage/Assistance: <ul style="list-style-type: none"> <input type="checkbox"/> Medicare-Approved Drug Discount Card <input type="checkbox"/> State Pharmacy Assistance Program <input type="checkbox"/> Union/Employer plan <input type="checkbox"/> Manufacturer's Assistance Program <input type="checkbox"/> Discount plans <input type="checkbox"/> Other: _____ 	Medicare (Parts A and B): <ul style="list-style-type: none"> <input type="checkbox"/> Enrollment, eligibility, benefits <input type="checkbox"/> Claims/billing <input type="checkbox"/> Appeals/quality of care/complaints Medicare Health Plans (HMOs, PPOs, PFFS, Special Needs Plans): <ul style="list-style-type: none"> <input type="checkbox"/> Enrollment, disenrollment, eligibility, comparisons <input type="checkbox"/> Plan or benefit changes/non-renewals <input type="checkbox"/> Claims/billing <input type="checkbox"/> Appeals/quality of care/complaints Medicaid (enrollment, eligibility, benefits): <ul style="list-style-type: none"> <input type="checkbox"/> QMB/SLMB/QI <input type="checkbox"/> Other Medicaid 	Medigap/Supplement/SELECT: <ul style="list-style-type: none"> <input type="checkbox"/> Enrollment, eligibility, comparisons <input type="checkbox"/> Change coverage <input type="checkbox"/> Claims/appeals Other: <ul style="list-style-type: none"> <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Fraud and Abuse <input type="checkbox"/> Military Health Benefits <input type="checkbox"/> Employer Health Plan or Federal Employee Health Benefits Program <input type="checkbox"/> Customer Service issues/complaints <input type="checkbox"/> Other: _____
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