

## State Health Insurance Assistance Program (SHIP) Resource Report Form

Name of Grantee Agency Reporting	State	6-month Report Period: ____ / ____ to ____ / ____ month / year                      month / year
Person Completing Report	Title	Telephone No.

SECTION 1 - NUMBER OF ACTIVE COUNSELORS AND HOURS	State Office	All Other Local and Field Sites	TOTAL	SECTION 2 - NUMBER OF LOCAL COORDINATORS/SPONSORS AND HOURS	TOTAL
a. # Volunteer Counselors				a. # Volunteer (unpaid) Coordinators	
b. # SHIP-Paid Counselors				b. # SHIP-Paid Coordinators	
c. # In-kind Paid Counselors				c. # In-kind Paid Coordinators	
TOTAL # Counselors (a+b+c)				TOTAL # Coordinators (a+b+c)	
d. Volunteer Counselor Hours				d. Volunteer (unpaid) Coordinator Hours	
e. SHIP-Paid Counselor Hours				e. SHIP-Paid Coordinator Hours	
f. In-kind Paid Counselor Hours				f. In-kind Paid Coordinator Hours	

SECTION 3 - NUMBER OF OTHER PAID STAFF AND HOURS	State Office	All Other Local and Field Sites	TOTAL	SECTION 4 - COUNSELOR TRAININGS	TOTAL
a. # SHIP-Paid Other Staff				a. # <b>Initial</b> Training(s) for New SHIP Counselors	
b. # In-kind Paid Other Staff				b. # New SHIP Counselors Attending <b>Initial</b> Training(s)	
c. SHIP-Paid Other Staff Hours				c. Total # Counselor Hours in <b>Initial</b> Training(s)	
d. In-kind Paid Other Staff Hours				d. # <b>Update</b> Training(s) for SHIP Counselors	
				e. # SHIP Counselors Attending <b>Update</b> Training(s)	
				f. Total # Counselor Hours in <b>Update</b> Training(s)	

SECTION 5 - NUMBER OF ACTIVE COUNSELORS WITH THE FOLLOWING CHARACTERISTICS					
<b>a. Years of SHIP Service:</b>		<b>c. Disability Status</b>		<b>e. Race/Ethnicity:</b>	
Less than 1 year		Disabled		American Indian or Alaska Native	
1 year up to 3 years		Not disabled		Asian	
3 years up to 5 years		Not collected		Black or African American	
Over 5 years				Hispanic or Latino	
Not collected				Native Hawaiian or other Pacific Islander	
				White, Not of Hispanic origin	
				Other	
				Not Collected	
<b>b. Age:</b>		<b>d. Gender</b>			
Less than 65 years of age		Female			
65 years or older		Male			
Not collected		Not collected			

SECTION 6 - WEB-SITE VISITORS (if applicable)
Total # of visits/visitors to web-site during the 2 quarters comprising the 6-month report period: 1st Quarter _____ 2nd Quarter _____

SECTION 7 - DID YOU WORK WITH ANY PARTNERS IN PROVIDING ANY SHIP SERVICES? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, check the type of partner involvement (check all that apply):  <input type="checkbox"/> Training <input type="checkbox"/> Counseling <input type="checkbox"/> Enrollment/application assistance (e.g. Medicare Prescription Drug Coverage activities) <input type="checkbox"/> Presentations <input type="checkbox"/> Outreach <input type="checkbox"/> Other
You are encouraged to include details of your partnership involvement in narrative form. Include names of key partnership organizations when possible.

SECTION 8 - ACTIVITIES, LESSONS LEARNED, SIGNIFICANT EVENTS
(Briefly describe on separate sheets. This section should address the following four topic areas: outreach (including activities targeted at underserved populations), information access and dissemination, training, and partnerships and networking.)