

## GROUP OUTREACH & EDUCATION FORM

**\* Items marked with asterisk (\*) indicate required fields**

<b>MIPPA Event *:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Send to SMP:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>SIRS eFile ID:</b> <b>(*required if sending record to SMP)</b> _____

<b>Event Details *</b>	
Session Conducted By *: _____	Partner Organization Affiliation* : _____
Total Time Spent on Event *: _____ Hours                      _____ Minutes	Title of Interaction *: _____
Number of Attendees * : _____	Type of Event * (select only one): <input type="checkbox"/> Booth/Exhibit (Health Fair, Senior Fair or Community Event) <input type="checkbox"/> Enrollment Event <input type="checkbox"/> Interactive Presentation to Public (In-Person, Video Conference, Web-based Event, Teleconference)
Start Date of Activity * : _____	
End Date of Activity : _____	

<b>Event Location *</b>	
State of Event * : _____	Zip Code of Event * : _____
County of Event * : _____	

<b>Event Contact Information</b>	
Event Contact First Name: _____	Event Contact Phone: _____
Event Contact Last Name: _____	Event Contact Email: _____

<b>Intended Audience * (multiple selections allowed):</b>		
<input type="checkbox"/> Beneficiaries	<input type="checkbox"/> Limited-English Proficiency	<input type="checkbox"/> People with Disabilities
<input type="checkbox"/> Employer-Related Groups	<input type="checkbox"/> Medicare Pre-Enrollees	<input type="checkbox"/> Rural Beneficiaries
<input type="checkbox"/> Family Members/Caregivers	<input type="checkbox"/> Partner Organizations	<input type="checkbox"/> Other

<b>Target Beneficiary Group * (multiple selections allowed):</b>		
<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Rural
<input type="checkbox"/> Asian	<input type="checkbox"/> Languages Other Than English	<input type="checkbox"/> N/A
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Low Income	<input type="checkbox"/> Not Collected
<input type="checkbox"/> Disabled	<input type="checkbox"/> Native Hawaiian or other Pacific Islander	<input type="checkbox"/> Other

<b>Topics Discussed * (multiple selections allowed):</b>		
<input type="checkbox"/> Duals Demonstration	<input type="checkbox"/> Medicare Fraud and Abuse	<input type="checkbox"/> Opioids
<input type="checkbox"/> Extra Help/LIS	<input type="checkbox"/> Medicare Part D	<input type="checkbox"/> Other Prescription Drug Coverage
<input type="checkbox"/> General SHIP Program Information	<input type="checkbox"/> Medicare Savings Program	<input type="checkbox"/> Partnership Recruitment
<input type="checkbox"/> Long-Term Care Insurance	<input type="checkbox"/> Medigap or Supplemental Insurance	<input type="checkbox"/> Preventive Services
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Original Medicare (Parts A and B)	<input type="checkbox"/> Volunteer Recruitment
<input type="checkbox"/> Medicare Advantage		<input type="checkbox"/> Other

(Continued on p.2)

**Special Use Fields**

Field 1: \_\_\_\_\_

Field 2: \_\_\_\_\_

Field 3: \_\_\_\_\_

Field 4: \_\_\_\_\_

Field 5: \_\_\_\_\_

**Notes**

Public Burden Statement:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0040). Public reporting burden for this collection of information averages 4 minutes per response, including time for gathering, maintaining, completing and reviewing the collection of information. The obligation to respond to this collection is required to retain or maintain benefits under the statutory authority from Section 4360(f) of the OBRA.