

STARS MEDIA OUTREACH & EDUCATION FORM

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

Start Date of Activity *: _____ End Date of Activity: _____

MIPPA Event *: Yes No

Send to SMP: Yes No

SIRS eFile ID:
 (*required if sending record to SMP) _____

Event Details *

Session Conducted By *: _____ _____	Partner Organization Affiliation* : _____ _____
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Total Time Spent on Event *: _____ Hours _____ Minutes	Title of Interaction *: _____ _____
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Type of Media * (select only one): <input type="checkbox"/> Billboard <input type="checkbox"/> Radio <input type="checkbox"/> Email <input type="checkbox"/> Social Media <input type="checkbox"/> Magazine <input type="checkbox"/> Television <input type="checkbox"/> Newsletter <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Other	Estimated Number of People Reached: _____ Geographic Coverage (select only one): <input type="checkbox"/> County or Counties <input type="checkbox"/> Regional <input type="checkbox"/> Multi-State <input type="checkbox"/> Statewide <input type="checkbox"/> National <input type="checkbox"/> Zip Code
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Event Location *

State of Event * : _____ Zip Code of Event * : _____

County of Event * : _____

Media Contact Information

Media Contact First Name: _____ _____	Media Contact Phone: _____ _____
Media Contact Last Name: _____ _____	Media Contact Email: _____ _____

Intended Audience * (multiple selections allowed):

Beneficiaries Medicare Pre-Enrollees Other
 Employer-Related Groups Partner Organizations
 Family Members/Caregivers

Target Beneficiary Group * (multiple selections allowed):

American Indian or Alaskan Native Hispanic/Latino Rural
 Asian Limited English Proficiency N/A
 Black or African American Low Income Other
 People with Disabilities LGBTQI+
 Native Hawaiian or other Pacific Islander

Topics Discussed * (multiple selections allowed):

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

(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 is estimated to average 4 minutes per response, including time for gathering and maintaining the data needed and completing and reviewing the collection of information. The obligation to respond to this collection is required to retain or maintain benefits.