

## STARS GROUP 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 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)	Delivery Method (select only one): <input type="checkbox"/> In-person <input type="checkbox"/> Web-based <input type="checkbox"/> Hybrid (in-person and web-based)
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Number of Attendees \*: \_\_\_\_\_

**Event Location \***

State of Event \* : \_\_\_\_\_ Zip Code of Event \* : \_\_\_\_\_

County of Event \* : \_\_\_\_\_

**Event Contact Information**

Event Contact First Name: _____ _____ -	Event Contact Phone: _____ _____ -
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Event Contact Last Name: _____ _____ -	Event Contact Email: _____ _____ -
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**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.