STARS TRAINING FORM

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

Training Month *: (MM)	
Training Day: (DD)	
Training Year *: (YYYY)	
Program*:	❑ MIPPA ❑ SHIP
Title of Training * :	
Part of a Multi-Day Series * :	❑ Yes ❑ No
Delivery Method * (select all that apply):	❑ In Person ❑ Online – Self Paced ❑ Virtual/Online ❑ In Person and Virtual/Online ❑ Other
Type of Training * (select only one):	❑ Initial ❑ Orientation ❑ Update
Submitted by * :	
Partner Organization Affiliation:	
Training Provider: (Multiple selections allowed)	❑ ACL ❑ CMS ❑ Medicaid Agency ❑ MIPPA Resource Center (NCBOE) ❑ Social Security Administration ❑ SHIP TA Center ❑ SMP Resource Center ❑ SHIP/SMP/MIPPA State/Local SHIP Created/Developed ❑ Other ACL Resource Center ❑ Other National Partner ❑ Other Federal Government Partner
Trainer 1 First Name and Last Name:	
Trainer 1 Additional Information:	
Trainer 2 First Name and Last Name:	
Trainer 2 Additional Information:	
Number of Attendees * :	
Attach Attendee List:	
Total Length of Training * :	_______ Hours _______ Minutes

Training Location

Location ZIP Code: ____

State / Territory * : ____

County of Training Location: ______________________________________

Location Address: ____

Location Contact First Name: ____

Location Contact Last Name: ____

Location Contact Email: ____

Location Contact Phone: (______) -__________ -____________

Geographic Coverage (select only one):	❑ Municipality ❑ County ❑ Regional ❑ Statewide ❑ Not Applicable

Training Topics * (At least one Training Topic selection is required. Multiple selections allowed)

Benefit Topics

- ❑ Coordination of Benefits
- ❑ Duals Demonstration
- ❑ Employer Health Benefits
- ❑ Long-term Care Insurance
- ❑ Marketing Regulations
- ❑ Medicaid
- ❑ Medicare Advantage (MA and MA-PD)
- ❑ Medicare Part D
- ❑ Medicare Plan Finder
- ❑ Medicare Savings Programs
- ❑ Medigap or Medicare Select
- ❑ Original Medicare (Parts A & B)
- ❑ Other Health Insurance
- ❑ Other Prescription Assistance
- ❑ Part D Low Income Subsidy (LIS/Extra Help)
- ❑ Preventive Services
- ❑ Veterans Health Benefits

Administrative Topics

- ❑ CMS Unique ID
- ❑ Confidentiality
- ❑ Complaints Tracking Module
- ❑ Customer Service/Counseling Skills
- ❑ Forms & Reporting
- ❑ MARx
- ❑ Performance Measures
- ❑ Presentation Skills
- ❑ Program Information
- ❑ Program Management
- ❑ Outreach

Special Use Fields

Field 1: _______________

Field 2: _______________

Field 3: _______________

Field 4: _______________

Field 5: _______________

Field 6: _______________

Field 7: _______________

Field 8: _______________

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 6 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.