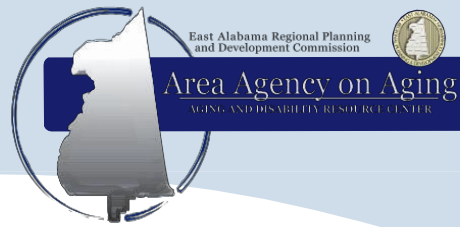


# Medicare Part D Client Intake Form



NAME ON MEDICARE CARD \_\_\_\_\_

MEDICARE CLAIM No.# \_\_\_\_\_ MARITAL STATUS: Single / Married / Widow  
(circle one)

EFFECTIVE DATE FOR PART A \_\_\_\_\_ PART B \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ RACE \_\_\_\_\_ GENDER \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(Street) (City) (County) (Zip Code)

PHONE NUMBER \_\_\_\_\_ ARE YOU DISABLED? YES / NO  
(circle one)

PHARMACY \_\_\_\_\_ INCOME \$ \_\_\_\_\_

DO YOU GET EXTRA HELP? YES / NO IF SO, WHICH KIND? QMB SLMB/QI-1LIS  
(circle one) (circle one)

DO YOU HAVE A *MY MEDICARE* ACCOUNT? YES / NO \_\_\_\_\_

CURRENT HEALTHCARE/DRUG COVERAGE: \_\_\_\_\_

WHICH PLAN WOULD YOU LIKE? \_\_\_\_\_ ADVANTAGE PLAN \_\_\_\_\_ DRUG PLAN ONLY

## MEDICATIONS

(Must have correct spelling, dosage & directions)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### For Office Use Only:

DATE OF INTAKE \_\_\_\_\_ TIME SPENT: \_\_\_\_\_ HOURS \_\_\_\_\_ MINUTES

TYPE OF INTAKE:    COMPARISON    ENROLLMENT

USERNAME: \_\_\_\_\_ PASSWORD: \_\_\_\_\_

NAME OF VOLUNTEER \_\_\_\_\_

**PLEASE SIGN THE BACK OF THIS PAGE →**

# State Health Insurance Assistance Program Client Agreement

The following has been explained to me and I agree to counseling under provisions and guidelines of the Alabama State Health Insurance Assistance Program (SHIP):

- These programs are intended to provide information regarding Medicare (Part A, Part B, and Prescription Drug Coverage), Medigap, Long Term Care Insurance, Medicare Advantage, Medicaid, Medicare Savings Programs and other benefit programs and health options that empower me to be informed of viable choices; exercise my individual rights and protections; and become a pro-active partner in my own health care decisions.
- Services are provided by trained volunteer counselors who are acting in good faith, and information given shall not be construed to legal advice.
- Counselors do not sell, recommend, or endorse any specific insurance product, agent, company, Medicare Advantage Plan, or Medicare Prescription Drug Plan, nor may they be actively affiliated with the insurance, financial planning industry or pharmaceutical industry. Any potential conflict of interest will be clearly disclosed to me.
- Counselors assume no responsibility for decisions made or actions taken by me I hold harmless the SHIP, the local East Alabama Regional Planning and Development Commission AAA/ADRC, the Alabama Department of Senior Services, and the counselor for any liability arising out of services provided within the program guidelines.
- Counselors will use information collected only in pursuit of assisting the client(s) and will not divulge confidential data to external sources other than Medicare service providers or insurance carriers in conjunction with counseling or assistance duties.

\_\_\_\_\_  
Name of Client (please print)

\_\_\_\_\_  
Counselor

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date



**PLEASE COMPLETE THE OTHER SIDE OF THIS PAGE →**