SHICK Senior Health Insurance Counseling for Kansas

PRESCRIPTION DRUG COVERAGE WORKSHEET

Return worksheet to:
Wildcat Extension District
Attn: SHICK Program
410 Peter Pan Road, Suite B
Independence, KS 67301
Phone: 620-331-2690 or dsteed@ksu.edu

Name as it appears on your Medicare Card:

_____

Medicare Number from Card

_____

Part A Effective Date:_____

Part B Effective Date:_____

Zip Code: _____

County:_____

Address:_____

City: _____ State:_____

Phone: (_____)_____

Email:_____

Do you have a MyMedicare Account?

Yes:_____ No:____

Account username : _____

Password: _____

Prefer not to share: ____

Current plan name and plan number:_____

Please name your top **two different** pharmacies choices:

_____

Race (optional)—Check All that Apply:

☐ Black or African American
☐ White
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Two or more races
☐ Other
☐ Choose not to respond

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

You may qualify for help paying for your prescription drugs

What best describes your income?

Single: ☐ Less than $19,380 per year ☐ Greater than $19,380 per year

Married: ☐ Less than $26,011 per year ☐ Greater than $26,011 per year

What best describes your liquid assets? Total value of savings, investments, and real estate *(not your primary home, vehicles, or burial plots)*.

Single: ☐ Less than $14,610 ☐ Greater than $14,610

Married: ☐ Less than $29,160 Greater than $29,160

K-STATE Research and Extension | Wildcat District

Please complete back side

Please list prescription drugs you take on a regular basis *(daily, weekly, or monthly)*. Do not list over the counter medications, dietary supplements or vitamins.

When entering your drug information, check to make sure you have spelled the name of the drug correctly. Make sure that you have entered the proper dosage and the amount that you would fill in a **ONE MONTH** period. If you take ***insulin*** please indicate the number of pens or vials that you use in **one month** period. **PLEASE PRINT CLEARLY. ATTACH AN EXTRA SHEET IF NEEDED.**

DRUG NAME	**DOSAGE (mg, mcg, etc..)**	**30– DAY QUANTITY ONLY (How many do you take or use in a month?)**
EXAMPLE: NOVOLOG	***100unit/ml solution pen***	***3ml pen (sold in pack of 5)***

The information that you provide will be used to compare plans on the Medicare.gov website. Information provided to you from the Medicare.gov website is an **estimate** and may be subject to change.