SULLIVAN COUNTY GOVERNMENT
Office for the Aging
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HIICAP Intake Form

Health Insurance Information, Counseling, and Assistance Program

PLEASE PRINT CLEARLY

Name _____ Date of Birth _____ Age _____

Physical Address _____

Mailing Address _____

Email Address _____

Best number[s] to reach you at:

_____

Married: Yes No
If yes, be sure to include income for spouse below.

Medicare #:

_____

Medicare effective dates from card:

HOSPITAL (PART A) __ __/__ __ / __ __ __ __

MEDICAL (PART B) __ __ /__ __ / __ __ __ __

ALL Monthly **GROSS** Income, List Source[s]:

_____

_____

Do you have a Medicare.gov account? Yes No

Username:

Password:

Are you a member of EPIC? Yes No
EPIC ID# _____

Medicaid Status:	Yes	No
Active	_____	_____
Pending	_____	_____

I would like assistance with the following (please check):

_____ Medicare Part D plan
_____ Medicare Supplemental Plans
_____ Completing enrollment in Medicare Part A/B
_____ Medicare Advantage Plans
_____ Something else

I currently have the following insurance coverage:

_____

Prescription Medications

List <u>all</u> prescription drugs. Please print clearly in blue or black ink. See example below.

Drug Name	*Dosage (mg/mcg)*	*Frequency*	*Tab/Capsule*
Example: <u>Simvastatin (generic for Zocor)</u>	**<u>25 mg</u>**	**<u>one/day</u>**	**<u>cap</u>**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14 .			
15.			

If additional space is needed, please continue on a separate piece of paper.

Please list the pharmacies you use and where they are located.

Pharmacy name _____ Town/village _____

Pharmacy name _____ Town/village _____

Please Sign/Date _____

Office Use Only

HIICAP Counselor _____ Date _____

Notes:

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HIICAP DISCLAIMER FORM

I understand that the HIICAP counselor provides health insurance counseling based on information currently available at www.medicare.gov (the official site of the Plan Finder), and based on information about personal prescription medications I will have provided to the counselor. I also understand that information on the Plan Finder site may not always reflect accurate and/or the most up-to-date information. It is my responsibility to follow up with the plan of my choice to verify coverage, cost, and answer any specific questions pertaining to the plan, prior to enrolling. I understand that the HIICAP counselor cannot advise me to choose one plan over another, and that it is up to me to decide and enroll in a plan of my choice, based on my needs and preferences. If I have reason to believe that the enrollment did not go through for some reason, I will notify the plan and HIICAP counselor right away.

HIICAP utilizes the Medicare.gov Plan Finder to compare Medicare Part D and Medicare Advantage drug plans. Medicare recently released new security requirements when accessing personal information within the Medicare Plan Finder. In order for HIICAP to perform a personal comparison for you, you will need to have an online MyMedicare.gov user account. You may already have one, but if not, a HIICAP counselor can assist you in setting one up.

By having an online MyMedicare.gov user account, you can:

- check your Medicare claims as soon as they are processed,
- find your eligibility, entitlement, and preventive service information,
- check your health and prescription enrollment information,
- view your Part B deductible information, and
- manage your prescription drug list.

For assistance during the Medicare Annual Election Period (AEP), I understand that enrollment in the plan must take place before December 7, or I risk incurring a late enrollment penalty, and/or be without needed coverage until the next opportunity for enrollment occurs.

I will not hold the HIICAP counselor/Sullivan County OFA liable for any or all consequences that will result from (1) my choice of plan, (2) submission of incomplete or incorrect information and/or (3) my delay in submitting for assistance.

_____ _____

Client's Name ~ Signature Date

_____

Client's Name ~ Print

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