HICAP

Medicare Prescription Drug Plan Finder Worksheet

For best results, please answer all questions in blue or black ink and print carefully:

Name: _____ **Birthdate:** _____

Address: _____

City: _____ **Zip Code:** _____

Phone: _____ **Email:** _____

Best time to call: _____

Medicare #: _____

Effective Dates of Medicare Coverage: **Part A:** _____ **Part B:** _____

Are you registered with MyMedicare.gov? Yes_____ No_____

Do you currently have Medi-Cal? Yes _____ No _____ Medi-Cal with Share of Cost? $_____

Do you have a separate drug plan? Plan Name: _____

Do you have a Medicare Advantage Plan? Plan Name: _____

Do you have (check any that may apply): ☐ **MediGap Plan** ☐ **Retiree Coverage** ☐ **TriCare for Life**

☐ **Employer Group Health Coverage** ☐ **Federal Employee Health Benefits** ☐ **VA health care benefits**

Do you have Extra Help (Low Income Subsidy) for prescription drug costs? Yes ___ No ___

If you think you might be eligible for Extra Help based on your income, we can help you apply.

- **Is your total gross monthly income (before any deductions from your checks):**
  -Less than or equal to $1,630 for single OR $2,198 for a couple? Yes ___ No ___
- **Are your assets (savings, stocks, bonds, etc.)**
  -Less than or equal to $14,790 for single OR $29,520 for a couple? Yes ___ No ___

HICAP DISCLOSURE STATEMENT: (Please initial after reading: _____)

HICAP counseling services are provided by trained counselors, registered by the California Department of Aging, who are acting in good faith to provide independent, impartial information about health insurance policies and benefits to clients. Counselors do not sell any type of health care coverage. They do not endorse or recommend any specific plan or policy. **Any information presented by HICAP volunteers should not be construed to be legal advice**, and volunteers are not liable for acts and omissions in providing counseling to recipients of service.

TURN PAGE OVER

CURRENT PRESCRIPTION DRUG COVERAGE

- **Please list all your prescription drugs, including dosages and frequency. Print carefully.**
- **Generic drugs will save you money. Do you want to consider generic drugs? Yes_____ No_____**
- **Name and address of your preferred pharmacy: _____**

  _____
- **Check preferences: Refills monthly _____ 90-day refills _____ Mail order _____**

COMPLETE NAME OF DRUG Example: Metoprolol Succinate ER Please indicate the Brand and type of insulin (e.g. Humalin R, Novolog, Solostar Pen 70/30, etc.)	**DOSAGE** Example: 50 mg.	**FREQUENCY** Example: 1 pill per day, 1 vial per mo., 2 inhalers per mo.
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PLEASE ATTACH ADDITIONAL SHEETS AS NEEDED		

SHIP
State Health Insurance Assistance Program

Navigating Medicare

Please mail, email, or fax completed worksheet to:
Legal Assistance for Seniors/HICAP
333 Hegenberger Road, Suite 850, Oakland, CA 94621
Telephone: 510-839-0393 or 1-800-434-0222
Email: las@lashicap.org
Fax number: 510-842-1080