SHIIP Client Information Form

Please provide the following information for our records.

What is your name on your Medicare card and address on record with Medicare?

First Name ______ M.I. ______ Last Name ______ Jr/Sr/I/II

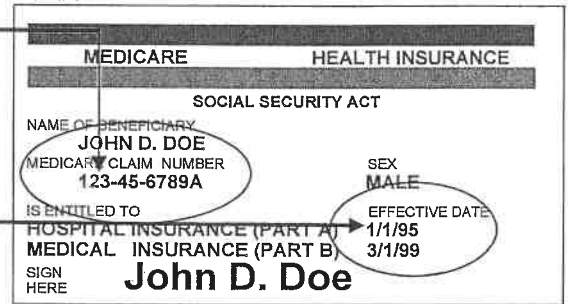
Client Address: ______

City: ______ State: ______ Zip Code: ______

Home Phone ______ Mobile Phone ______

Email Address ______ County ______

What is your Medicare Claim Number on your Medicare card?



What is your Medicare effective date(s)?

Part A--Month ☐☐ - Day ☐☐ - Year ☐☐☐☐

Part B--Month ☐☐ - Day ☐☐ - Year ☐☐☐☐

Representative Information (Son, Daughter, Friend or POA)

Representative's Name ______

Rep Address ______

City ______ State ______ Zip Code ______

Phone ______ Email Address ______

Client Demographics

Date of Birth ______ / ______ / ______ **Gender:** M ____ F ____

Primary Language English ______ Other ______

Is your income above or below the following amounts: Above ______ Below ______
Individual--$18,450/yr ($1,538/mo) or Couple--$24,930/yr ($2,078/mo)

Are assets above or below the following amounts: Above ______ Below ______
Individual--$14,100 or Couple--$28,150

On Medicare Due to a Disability (under age 65): Yes ______ No ______

SHIIP Use Only: Premium Payment SSA ☐ Direct Bill ☐

Contact Person: ______ Phone

Ethnicity/Race: Please select one of the following.

- ______ Hispanic, Latino, or Spanish Origin
- ______ White, Not if Hispanic Origin
- ______ Black, African-American
- ______ American Indian or Alaska Native
- ______ Asian Indian
- ______ Chinese
- ______ Filipino
- ______ Japanese
- ______ Korean
- ______ Vietnamese
- ______ Native Hawaiian
- ______ Guamanian or Chamorro
- ______ Samoan
- ______ Other Asian
- ______ Other Pacific Islander
- ______ Other ______________

How did you hear about SHIIP?

- ______ Medicare (e.g. 800#, Publication, Mailing)
- ______ Presentations or Fairs
- ______ Mailings, Brochures, Posters or Newsletters
- ______ Agency (e.g. AAA, Social Security Administration)
- ______ Friend or Relative
- ______ Media (Newspaper, TV, Radio or Other Ad)
- ______ Medical Provider
- ______ Pharmacy
- ______ Insurance Agency or Provider
- ______ Prior Contact
- ______ SHIIP Website
- ______ Other

Complete this information only if you need a Medicare Part D Comparison

What is your current drug coverage? Check any that apply.

- ☐ Medicare Part D Plan
  Plan Name ______________________
- ☐ Medicare Advantage Plan
  Plan Name ______________________
- ☐ TRICARE for Life
- ☐ VA benefits
- ☐ None
- ☐ Employer/Retiree plan
- ☐ Federal Employee Health Benefit Plan
- ☐ Other ______________________

How would you like to get your Medicare drug benefits? Please provide a comparison of (check one):

☐ Medicare drug plans only ☐ Medicare Advantage Plans only ☐ Both

Do you currently receive any of the following benefits?

- ☐ Medicaid (Title 19 - MEPD, SSI, Elderly Waiver, Medically Needy Spend-down, Nursing Home)
- ☐ Help paying your Medicare Part B premium (QMB, SLMB, QI)
- ☐ Extra Help with your Medicare drug costs
- ☐ Pay $1.25 for generics and $3.70 for brand name drugs
- ☐ Pay $3.35 for generics and $8.35 for brand name drugs

What pharmacy do you prefer? You may list two.

Name of Pharmacy	Address and City	Phone Number
Name of Pharmacy	Address and City	Phone Number

Please complete and mail back to Crossroads as soon as possible at 712 Union Street #301, Pella IA 50219. Any questions call 641-628-1212. Thanks!

Name of Drug	Brand or Generic	Dosage	Frequency
Example: Lipitor	Brand	10mg	1/day
Example: Latanoprost	Generic	10ml	1 bottle/month

Do you take insulin for diabetes? ______________________________

What is SHIIP?

SHIIP is a free, unbiased, counseling program provided by the State of Iowa Insurance Division. This form contains confidential information and will not be shared with anyone other than your SHIIP Counselor(s).