Saratoga County Office for the Aging

Health Insurance Information, Counseling, and Assistance Program

First Name: _____ Last Name: _____

Date of Birth: __ __ /__ __ /__ __ __ __ Age: ____

Address: Street _____ City _____ State _____ Zip _____

Monthly Gross Income

Total $ _____

	Self	+	Spouse
Social Security	$_____		$_____
Pension	_____		_____
Other	_____		_____

Phone: (__ __ __) __ __ __ - __ __ __ __

Email: _____

Marital Status: Married [ ] Single [ ]

Veteran: Yes [ ] No [ ]

Current Medicare Plans

Medicare Effective Dates From Card
Part A: __ __ / __ __ / __ __ __ __
Part B: __ __ / __ __ / __ __ __ __

Name of Part D Prescription Drug Plan:

_____

Do you have either type of plan below?

Medigap Supplemental Plan Company:

_____

With Medigap Plan Letter A-N ____

OR

Name of Medicare Advantage Plan:

_____

Do you have any of the following?

NYS EPIC	Yes [ ]	No [ ]
Medicaid	Yes [ ]	No [ ]
NYS Benefit Card	Yes [ ]	No [ ]
Extra Help	Yes [ ]	No [ ]
Medicare Savings Program	Yes [ ]	No [ ]

Where did you hear about this Counseling Service: _____

For questions, please contact:

Saratoga County Office for the Aging

152 West High Street, Ballston Spa, NY 12020

(518) 884-4100

What is the specific issue you need assistance with? For example, are you new to Medicare, are you retiring, do you need additional coverage or having trouble with prescriptions?

_____

_____

_____

Prescription Medications

*List **all** prescription drugs. List **EXACTLY** as printed on bottle/label. See example below.*

	Drug Name	Dosage (mg/mcg)	Frequency	Taken For
Example:	Simvastatin (generic for Zocor)	25 mg	one/day	cholesterol
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10				
11				
12				
13				
14				
15				

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

Pharmacy name _____ Address _____

Pharmacy name _____ Address _____

I understand that the HIICAP volunteer counselor provides health insurance counseling based on information currently available at https://www.medicare.gov/ (the official site of the Planfinder), and based on information about personal prescription medications that I will have provided to the counselor. I also understand that information on the Planfinder site may not always reflect accurate and/or the most up-to-date information. It will be up to me to follow up with the plan of my choice to verify coverage and costs prior to enrolling. I understand that the HIICAP volunteer 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. I will not hold the HIICAP volunteer counselor liable for any or all consequences that will result from my choice of plan.

Signature: _____ Date: __ __ / __ __ / __ __ __ __