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NEBRASKA SENIOR HEALTH INSURANCE INFORMATION PROGRAM (SHIIP) CLIENT CONTACT FORM

Section 1 - Client / Counselor Information

Counselor Name: _____ First _____ Last

Counseling Location Zip Code: __ __ __ __ __

Counseling Location County: _____

Client Name: _____ First _____ Last

Client Zip Code: __ __ __ __ __

Drug List ID:_____

Password Date:_____

Section 2 - Counseling Session Information

Date of Contact:

__ __/__ __/__ __ __ __
month / day / year

How Did Client Learn About the SHIIP: (check only one)

o Previous Contact o Medicare o Congressional office o Partner Agency
o SHIIP Event o Social Security o Drug/Health Plan o SHIIP Website
o SHIIP Media o Friend/Relative o Medicaid o Other

Method of Contact:
o Phone call o Email
o In Person (site) o Mail / Fax
o In Person (client's home) o WebEx

Age:
o under 65
o 65-74
o 75-84
o 85 or older

Race:
o American Indian or Alaska Native
o Asian
o Black or African American
o Hispanic or Latino
o White, Non-Hispanic
o Other

Client Monthly Income for 2019:
$1,581 / individual *$2,134 / couple*
o Less than above o More than above

Receiving or Applying for Medicare due to Disability:
o Yes o No

Gender:
o Female
o Male

Primary Language:
o Other o English

Client Assets for 2019:
$14,390 / individual, $28,720 / couple
o Less than above o More than above

Section 3 - Topics Discussed

Did you discuss Medicare fraud, waste or abuse? o Yes o No *Please check fraud topic below*

Medicare (Parts A & B):
o Appeals/Grievances/Quality of Care
o Eligibility, Benefit Explanation
o Claims/Billing
o Enrollment/Disenrollment
o **Fraud & Abuse**

Medicare Supplement/Medigap:
o Benefits Explanation
o Claims/Billing
o Eligibility
o **Fraud and Abuse, Marketing Complaints**
o Plan Non-Renewal
o Plan Comparison

Medicare Advantage:
o Appeals/Grievances
o Claims/Billing
o Disenrollment
o Eligibility, Benefits
o Enrollment
o **Fraud and Abuse, Marketing Complaints**
o Plan Comparison

Medicare Prescription Drug Coverage:
o Appeals/Grievances
o Benefits
o Claims/Billing
o Disenrollment/Non-Renewal
o Eligibility
o Enrollment
o Appeals/Grievances
o Fraud and Abuse, Marketing Complaints
o Plan Comparison

Part D Low Income Subsidy (LIS/Extra Help):
o Application Submitted
o Benefits Explanation
o Claims/Billing
o Eligibility/Screening
o LINET / BAE

Other Prescription Assistance:
o Manufacturer Programs/Discount Plans
o Military Drug Benefits
o Employer/Retiree Plan

Medicaid (Heritage Health):
o Medicaid Application Assistance
o Benefit Explanation
o Claims/Billing
o Eligibility
o **Fraud and Abuse**
o Other

Other:
o Employer Health Benefits
o COBRA
o Long Term Care (LTC) Insurance
o LTC Other
o Other Health Insurance
o Retiree Health Benefits
o TRICARE for Life
o VA Benefits
o Other (Prevention, Online Tools, CHIP, etc.
o Dental/Vision
o **New Medicare Card**

Section 4 - Session Completion

Total Time Spent:

_____ hours _____ minutes

Status: (check only one)
o In Progress o Complete

Did You Enroll in Part D?

Old Plan Yearly Total: $ _____

New Plan Yearly Total: $_____

Enrollment Confirmation: _____

Non Part D Savings

Amount Saved: $_____

Reason for Savings:_____

Counselor Name: **County:** **Zip Code:**

Client Name	Zip	Date	Method/ Contact	Disabled	Age	Gender	Non English	Low Income	Discuss Fraud?	Topics Covered	Minutes Spent	Other Savings $	Part D Enroll Confirm #	Old Plan $	New Plan $

Counselor Name: **County:** **Zip Code:**

Client Name	Zip	Date	Method/ Contact	Disabled	Age	Gender	Non English	Low Income	Discuss Fraud?	Topics Covered	Minutes Spent	Other Savings $	Part D Enroll Confirm #	Old Plan $	New Plan $

Counselor Name: **County:** **Zip Code:**

Client Name	Zip	Date	Method/ Contact	Disabled	Age	Gender	Non English	Low Income	Discuss Fraud?	Topics Covered	Minutes Spent	Other Savings $	Part D Enroll Confirm #	Old Plan $	New Plan $