Medicare Part D Worksheet

Online Medicare Account

Clients must complete this questionnaire and have an Online Medicare account for VICAP* counselors to prepare a personalized Medicare Part D drug insurance analysis. All questions must be answered. Information will be kept confidential by VICAP counselors and staff.

Check one of the following:

◯ I do not have an Online Medicare account, and I want a personalized search. I give permission for the Loudoun VICAP Counselors to create an Online Medicare account for me. Counselors will send me the account information if I request it.

◯ I have an Online Medicare account and I want a personalized search. Here is the account information:

User Name: _____

Password: _____

◯ I do not want an Online Medicare account. I understand that VICAP will not be able to prepare a personalized analysis of my options.

I understand that the counselors will use the information provided on this form to assist me with my Part D or Part C coverage options and will keep my information confidential.

**The VICAP program is a part of the federal SHIP counseling programs financed in part through federal grants from the US Administration for Community Living, Department of Health and Human Services, Washington, D.C.*

Signature _____ _____

(Signed or Typed Name) Date

Medicare Part D Worksheet

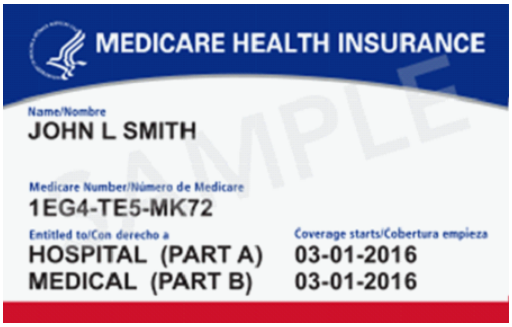
Persons with Medicare may select a Medicare Part D prescription insurance plan: (1) when you first enroll in Medicare, (2) when you move, (3) every year during the Open Enrollment Period. All insurance plans change every year, so Medicare beneficiaries should compare coverage each year during the Open Enrollment Period, **October 15 – December 7**, of each year.

1. ZIP code _____ Previous ZIP code _____

2. Medicare Number _____

   ◯ Mr.
   ◯ Mrs.
   ◯ Ms.

Medicare Number >>>>



_____ _____ _____ _____

Last Name First Name M.I. Jr, Sr, II, III

4. Mailing Address _____ _____

Street Address Apartment #

_____ _____

City State

5. Email Address _____

6. Telephone – Preferred _____

   Other _____

7. Date Your Medicare Starts (found on Medicare card)

   Hospital (Part A) _____ Medical (Part B) _____

   mm/dd/yyyy mm/dd/yyyy

8. Date of Birth: _____

   mm/dd/yyyy

9. Other person to contact (relative, friend, etc.) Optional

   Name: _____

   Relationship: _____

   (wife, husband, son, daughter, friend, etc.)

   Telephone _____ email _____

   Address: _____

10. What coverage do you have now? Check all that apply.

☐ Medicare Prescription Drug Plan Full Name of Current Plan

☐ Medicare Advantage Plan Full Name of Current Plan

☐ Virginia Medicaid Full Name of Current Plan

☐ Retiree Plan that is ending. Date this ends: _____

☐ Current employee insurance that is ending. Date this ends:_____

☐ None of the above.

11. Do you get financial help (called “Extra Help”) with Medicare drug costs?

If you currently get financial "Extra Help", check **Yes** and **Skip** to Question 16.

☐ Yes ☐ No ☐ Don’t know

12. To be screened for Extra Help, please answer the questions below and speak with a Medicare Counselor to determine if you may be eligible for financial help. If eligible, a counselor can help you apply.

13. Is your gross income from all sources **GREATER** than:

- **$1,843/month** if Single, Widow, or Married and living apart, or
- **$2,485/month** if Married and living together

☐ Yes ☐ No

14. Are your combined savings, investments & real estate **GREATER** than the following? (Do not include your home, vehicle, personal possessions, or burial expenses.)

$16,660 f you are Single, Widow, or Married living apart, or **$33,240** if you are Married and living together.

☐ Yes ☐ No

15. Do you have children or grandchildren living with you in <u>your</u> house? (If yes, you may qualify for financial assistance with a higher income.)

☐ Yes ☐ No

16. **Please read directions carefully & Print in the box below.**

- Give exact name of drug, including ER, XR, etc. after the name
- If you take generics, give only the generic name.
- List the strength of each drug (for example 100mg,or 0.3% solution)
- List how much do you need for **ONE month** (even if you buy a 90-day supply)
  - **Number** of pills, tablets, capsules you need for **ONE month (30 days)**
  - **Size** of bottles or tubes & **number** you need for **ONE month (30 days)**
  - **Number of boxes of units** (e.g 1 box of 5 insulin pens) for **ONE month**
  - **Number of inhalers** (**NOT** number of puffs per day) for **ONE month**

Your analysis will be delayed, if we do not have your complete, correct information.

	Name of Prescription Drug **Specify** TABLET or CAPSULE GELL or LOTION SOLUTION or SPRAY,etc.	**Dosage** (example: 500mg for pills, tablets, capsules; **or** 0.5% for solutions or creams) **Size** (2.0 ml bottle, box of 14, or .5 oz tube)	**How Many pills, tubes, bottles, etc. do you use in one month?** Do NOT put **"as needed"**
	Example: Atorvastatin Tablet	***20 mg***	***30 per month***
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9			
10.			
11.			
12.			
13.			
14.			

17. List 4 pharmacies you may use. We suggest you include at least one large, national pharmacy (like Walgreens, CVS or Walmart), as they have lower drug co-pays with some insurance plans and you'll save money.

Pharmacy Name: _____ Pharmacy Name: _____

City: _____ City: _____

Pharmacy Name: _____ Pharmacy Name: _____

City: _____ City: _____

18. Do you want prices for Mail Order? ☐ Yes ☐ No

19. **Comments:** (Examples: My Medicare starts June 1; I moved to Loudoun & need my drug plan to start as soon as possible; I take all generic drugs; please contact my son with analysis results, etc.)

Using the information on this worksheet, you, a friend, or family member can run your analysis on the www.Medicare.gov website. **Or,**

If you want the **Loudoun County VICAP Medicare Counseling Program** to run the analysis for you, return your completed worksheet in one of the ways listed below**.**
We will contact you when your analysis is complete.

- **Mail or Drop Off:**

  Loudoun County Dept. of Parks, Recreation, & Community Services -- Area Agency on Aging
  c/o VICAP Medicare Counseling Program
  742 Miller Drive, SE
  PO Box 7800
  Leesburg, VA 20177-7800

- **Email** AAAMedicare@Loudoun.gov (or to the counselor who sent it to you)

VICAP
VA Insurance Counseling & Assistance Program
HELPING YOU NAVIGATE MEDICARE

6-1-2023