SHIP Client Contact Form

(Items marked with an asterisk * indicate required fields.)

### Client Name and Contact Information

<table>
<thead>
<tr>
<th>Client First Name:</th>
<th>Client Last Name:</th>
<th>*Client ZIP Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Phone Number:</th>
<th>Representative First Name:</th>
<th>*Client County:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Counselor and Agency

<table>
<thead>
<tr>
<th>*Counselor:</th>
<th>*County of Counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Agency:</th>
<th>*ZIP Code of Counselor:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Date Of Contact: *How Did Client Learn About SHIP:

**First vs Continuing Contact:**
- First Contact for Issue
- Continuing Contacts for Issue

**How Did Client Learn About SHIP:**
- Previous Contact
- CMS / Medicare Presentations
- Mailings
- Another Agency
- Friend or Relative
- Media
- State Website
- Other

### Method of Contact:

<table>
<thead>
<tr>
<th>Method of Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Call</td>
</tr>
<tr>
<td>Face to Face at Counseling Location or Event Site</td>
</tr>
<tr>
<td>Face to Face at Client’s Home or Facility</td>
</tr>
<tr>
<td>EMail</td>
</tr>
<tr>
<td>Postal Mail or Fax</td>
</tr>
</tbody>
</table>

### Client Age Group: *Client Gender: *Client Primary Language Other Than English:

- 64 or Younger
- 65-74
- 75-84
- 85 or Older

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Primary Language Other Than English:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>English is Client’s Primary Language</td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
</tbody>
</table>

### Client Race-Ethnicity:

- Hispanic, Latino, or Spanish Origin
- Filipino
- Guamanian or Chamorro
- White, Non-Hispanic
- Japanese
- Samoan
- Black, African American
- Korean
- Other Asian
- American Indian or Alaska Native
- Vietnamese
- Other Pacific Islander
- Asian Indian
- Native Hawaiian
- Some Other Race-Ethnicity
- Chinese
- Not Hawaiian
- Some Other Race-Ethnicity
- Not Collected
- Not Collected
- Not Collected

### Client Monthly Income: *Client Assets: *Receiving or Applying for Social Security Disability or Medicare Disability: *Dual Eligible with Mental Illness / Mental Disability:

- Below 150% FPL
- Below LIS Asset Limits
- Yes
- Yes
- At or Above 150% FPL
- Above LIS Asset Limits
- No
- No
- Not Collected
- Not Collected
- Not Collected
- Not Collected
### SHIP Client Contact Form

#### Medicare Prescription Drug Coverage (Part D):
- [ ] Eligibility/Screening
- [ ] Benefit Explanation
- [ ] Plans Comparison
- [ ] Plan Enrollment/Disenrollment
- [ ] Claims/Billing
- [ ] Appeals/Grievances
- [ ] Fraud and Abuse
- [ ] Marketing/Sales Complaints or Issues
- [ ] Quality of Care
- [ ] Plan Non-Renewal

#### Part D Low Income Subsidy (LIS/Extra Help):
- [ ] Eligibility/Screening
- [ ] Benefit Explanation
- [ ] Application Assistance
- [ ] Claims/Billing
- [ ] Appeals/Grievances

#### Other Prescription Assistance:
- [ ] Union/Employer Plan
- [ ] Military Drug Benefits
- [ ] Manufacturer Programs
- [ ] State Pharmaceutical Assistance Programs
- [ ] Other ______________________________

### Medicare (Parts A & B):
- [ ] Eligibility
- [ ] Benefit Explanation
- [ ] Plans Comparison
- [ ] Plan Enrollment/Disenrollment
- [ ] Claims/Billing
- [ ] Appeals/Grievances
- [ ] Fraud and Abuse
- [ ] Quality of Care

#### Medicare Advantage (HMO, POS, PPO, PFFS, SNP):
- [ ] Eligibility/Screening
- [ ] Benefit Explanation
- [ ] Plans Comparison
- [ ] Plan Enrollment/Disenrollment
- [ ] Claims/Billing
- [ ] Appeals/Grievances
- [ ] Fraud and Abuse
- [ ] Marketing/Sales Complaints or Issues
- [ ] Quality of Care
- [ ] Plan Non-Renewal

#### Medicaid:
- [ ] Medicare Savings Programs (MSP) Screening (QMB, SLMB, QI)
- [ ] MSP Application Assistance
- [ ] Medicaid (SSI, Nursing Home, MEPD, Elderly Waiver) Screening
- [ ] Medicaid Application Assistance
- [ ] Medicaid/QMB Claims
- [ ] Fraud and Abuse

#### Other:
- [ ] Long Term Care (LTC) Insurance
- [ ] LTC Other
- [ ] Military Health Benefits
- [ ] Employer/Federal Employee Health Benefits (FEHB)
- [ ] COBRA
- [ ] Other Health Insurance
- [ ] Other: Specify ______________________________

#### Status:
- [ ] General Information and Referral
- [ ] Detailed Assistance - In Progress
- [ ] Detailed Assistance - Fully Completed
- [ ] Problem Solving / Problem Resolution - In Progress
- [ ] Problem Solving / Problem Resolution - Fully Completed

*Total Time Spent on this Contact Date:
______ Hours   ______ Minutes*

**Comments:**
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____________________________________________________________________________________

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Illinois Department on Aging, Senior Health Insurance Program (SHIP)