MEDICARE PART D
PLAN COMPARISON WORKSHEET

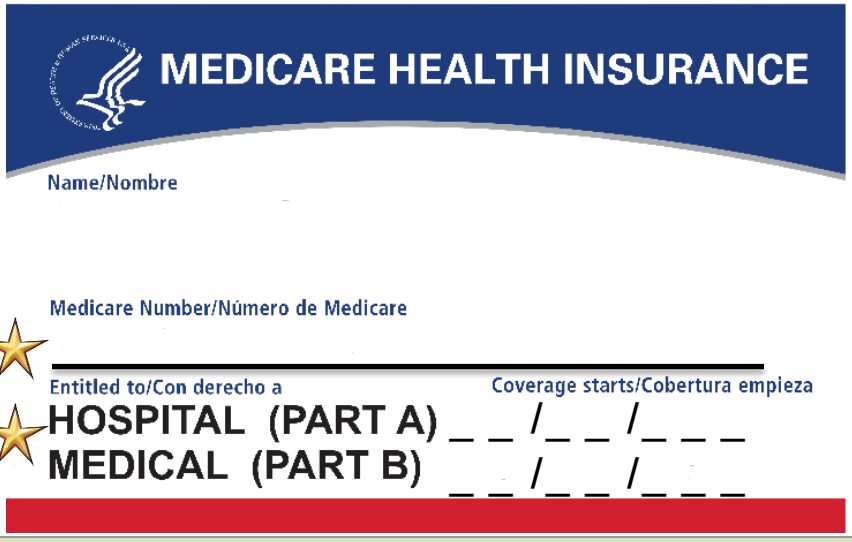
WEBSITE: WWW.SHIINE.NET

SHIINE
senior health information & insurance education

The following questionnaire provides the information necessary for SHIINE to prepare a personalized report. The collection of this data will help develop and improve the services that SHIINE provides.

Name (First, MI, Last):		
Current Address:		
City:	State:	ZIP Code:
Phone:	County:	Date of Birth: _ _ / _ _ / _ _
Email:	☐ I would like to receive updates from SHIINE.	

Please fill in your card information below:



Gender: ☐ Male ☐ Female

2018

Is your monthly income
☐ Above ☐ Below
$1,538 (single) or $2,078 (couple)?

Is the value of your assets
(not including home or vehicle)
☐ Above ☐ Below
$14,100 (single) or $28,150 (couple)?

Enrolled in Extra Help? ☐ Yes ☐ No

☐ Yes ☐ No Do you reside in a Nursing Home?

☐ I reside in South Dakota year round.

Language (other than English):

Ethnicity:
- ☐ Hispanic, Latino or Spanish
- ☐ Black, African American
- ☐ Asian Indian
- ☐ White, Non-Hispanic
- ☐ Native American
- ☐ Other (please specify):

Are you receiving Medicare due to a disability? ☐ Yes ☐ No

Do you currently receive Medicaid benefits? ☐ Yes ☐ No

SHIINE OFFICE LOCATIONS

Eastern South Dakota
2500 W 46th Street
Suite 101
Sioux Falls, SD 57105
1-800-536-8197
easternoffice@shiine.net

Central South Dakota
2520 E Franklin Street
Pierre, SD 57501
1-877-331-4834
centraloffice@shiine.net

Western South Dakota
2200 N Maple Suite 104
Rushmore Mall
Rapid City, SD 57701
1-877-286-9072
westernoffice@shiine.net

Please attach a printed prescription listing from your pharmacy.
If you cannot obtain, fill out this chart and attach additional sheets if necessary.

Name of Drug *Example: Lipitor*	**Strength** *Example: 10 mg*	**Daily Dosage** *Example: twice daily*

Preferred Pharmacy (up to two): Pharmacy Name and City	
1.	2.
☐ I would be willing to use a different pharmacy.	☐ I prefer to use a mail order pharmacy.

By signing below, I acknowledge that I am making my enrollment, or non-enrollment, decision freely and voluntarily. While I may receive information from a counselor with the Senior Health Insurance Information and Insurance Education (SHIINE) program, the final decision will be made of my own free will and choice. I understand that the counselor who assists me may be a volunteer and will only provide me with information to assist me in my decision. I further understand that drug pricing data available on the www.medicare.gov Plan Finder is only an estimate and subject to change. I hereby release any and all liability that may possibly be attributable to the volunteer counselor and agree not to pursue any legal action against the counselor and/or SHIINE for actions taken in their capacity as a volunteer counselor.

Signature	**Date**

FOR OFFICE USE ONLY

Counselor Name:	**Date(s):**	**Entered in STARS** ☐
Current Plan Annual Premium: $	**New Plan Annual Premium: $**	
Notes:		
Drug List ID and Date:	**Enrollment Confirmation #:**	

	Eligibility/ Screening	Benefit Explanation	Plan Comparison	Enrollment/ Disenrollment	Claims/ Billing	Appeals	Fraud and Abuse **(SMP)**	Marketing/ Sales Complaints	Quality of Care	Plan Non-renewal
Prescription Drug (Part D)										
LIS/Extra Help										
Parts A & B										
Medicare Advantage										
Medigap										
☐ Under age 65, receiving Medicare due to disability										

	Employer (Union) Plan
	Military Health Benefits
	COBRA
	Long Term Care Insurance
	Refer to Manufacturer Program
	LI NET for New to Extra Help
	Medicare Savings Programs
	MSP Application Assistance
	Medicaid /QMB Claims
	Other:

Status

	General Information and Referral
	Detailed Assistance – In Progress
	Detailed Assistance – Fully Complete
	Problem – In Progress
	Problem – Fully Completed

Time Spent:

____ Hours ____ Minutes