ADULT RESOURCE Alliance of Yellowstone County

KEEPING ADULTS 60 AND ABOVE INDEPENDENT AND INVOLVED

Thank you for your interest in having the Resource Center staff help you explore your Medicare Part D plan options for 2025. The 2025 plans will be available for review in early October. If there is a more cost-effective plan for you, you will receive a call offering you an appointment to review your options.

Please provide all of the following information on the enclosed sheets so that we have the needed information to assess whether your current plan is a good choice for 2025:

- Medicare information as it appears on your Medicare card.
- Your preferred pharmacy.
- Your enrollment status in other health care programs such as Medicaid, Extra Help, or Big Sky RX.
- Information about your income and assets.
- A list of your current prescription medications, including the dosage and quantity required per day. Please do not include over-the-counter medications such as vitamins.
- A Medicare.gov account is needed to accurately review your options. Please complete and return the attached sheet, with your signature, so we can help you manage this account.
- Finally, please read, sign, and date the white "Client Agreement and Authorization" form. This form is required each year.

Please return completed worksheets to:

Resource Center Open Enrollment

PO Box 20895

Billings, MT 59104

***Please note: Worksheets are processed in the order in which they are received. The Resource Center offers self-help kiosks for your use, with SHIP counselor guidance available to assist you.**

The Resource Center Staff

The Resource Center does not charge any fees for its services; however, donations help us continue these important services and are always greatly appreciated.

AVP Volunteer Program
406-245-6177

Meals on Wheels
Billings:
406-259-9666
Laurel:
406-628-7571

Resource Center
406-259-5212

Senior Lunch Program
406-259-9666

Transportation Services
406-294-1590

AllianceYC.org
1505 Ave D, Billings, MT 59102
406-259-9666 | FAX: 406-259-2849

935 Lake Elmo Dr, Billings, MT 59105
406-606-1170 | FAX: 406-281-8027

Please return completed worksheet to:
P.O. Box 20895, Billings, MT 59104
PH: 406-259-5212 Fax: 406-259-2849
Email to: rc@allianceyc.org

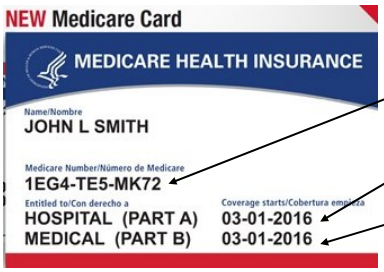
Resource Center
2025 Medicare Part D Drug Plans Assessment Worksheet

Name on Medicare Card:_____ Date of Birth:_____

Address:_____ City:_____ Zip Code:_____

Phone #: _____Email:_____

Preference for Appointment: ☐ Self-help Kiosk ☐Phone ☐Face to Face
*see page 1



MEDICARE # __ __ __ __ - __ __ __ - __ __ __ __

Effective Date Part A __ __ - __ __ - __ __ __ __

Effective Date Part B __ __ - __ __ - __ __ __ __

Name of preferred pharmacy:_____ Zip Code: _____

Number of individuals in household including dependents: ☐1 ☐ 2 ☐ 3 ☐ 4 or more_____

Are you currently eligible for VA drug benefits? ☐ Yes ☐ No

Name of your current Medicare Part D prescription plan: (Examples: Humana Walmart Value, SilverScript Choice, ClearSpring Health Value Rx, AARP MedicareRx SaverPlus, Wellcare Classic, etc)

_____

Your current Medicare Part D Prescription Drug plan monthly premium: **$**_____

Do you have any of the following health care programs? (Check all that apply)

☐ Medicaid ☐ Social Security "Extra Help" ☐ Big Sky RX

OFFICE USE ONLY:

Date Received_____**Entered by**_____**Reviewed by**_____**Appt. needed Y / N Date/time**_____**w/**_____

Please list all your Rx medications on the following list. Be sure to include all letters and numbers in addition to the name of the drug. If your medication is in vials or tubes, please list the number of vials or tubes you need in one month. If you take medication as needed, list the approximate amount used per month.

PLEASE PRINT	Please check 1		*You may find it easier to request this list from your pharmacist*	
NAME OF MEDICATION	Brand	Generic	STRENGTH (ml, mg, G, etc.)	How often do youtake?

Please read and complete the two additional white sheets in their entirety and return them with pink sheet.

PLEASE COMPLETE THIS SHEET AND RETURN WITH RX WORKSHEET

MyMedicare.gov Registration

There has been a change to how personal information will be stored by Medicare.
To be able to retrieve your drug information, it must be stored in your personal MyMedicare.gov account. This means if we want to find out what drug plan you currently have, what your medications currently cost, and if you have any assistance with your medication cost, you will have to establish a MyMedicare.gov account. This can be accomplished one of two ways:

OPTION ONE: You log on to MyMedicare.gov and establish your account yourself.

Then include on this sheet your Username _____

And Password _____

OPTION TWO: We will set up your MyMedicare.gov account for you.

☐ I give permission for the Resource Center staff to complete MyMedicare.gov registration.

Name: _____Date_____

MY MEDICARE.GOV ENROLLMENT INFORMATION

We will provide your completed account information to you by mail or at your appointment. To insure you will be able to access your account if you forget your password, you will need a secret word code. **The secret word code is the answer to any ONE of these following questions. Pick ONE question that has an answer that will be easy for you to remember.**

1)What is your favorite vacation spot? _____

OR

2)What is the name of the first street you lived on? _____

OR

3)What was the name of your first pet? _____

OR

4)What is your best friend's last name _____

OR

5)What is the title of your favorite book? _____

You will receive a letter from Social Security stating that a mymedicare.gov account has been opened for you. Please do **NOT** deactivate it or we will be unable to assist you with your Medicare.

A card with your mymedicare.gov account information will be placed here after review.

PLEASE RETAIN CARD FOR YOUR RECORDS.

LOCAL HELP FOR PEOPLE WITH MEDICARE

STATE HEALTH INSURANCE ASSISTANCE PROGRAM
Client Agreement and Authorization

This program is intended to provide information regarding Medicare (Part A, Part B, and Prescription Drug Coverage), Medigap, Long Term Care Insurance, Medicare Advantage, Medicaid, and other health benefit programs and health options to empower you to be informed of viable choices; exercise your individual rights and protections; and become a pro-active partner in your own health care decisions.

- Services are provided by trained volunteers/counselors who are acting in good faith and information given shall not be construed to be legal advice.
- Volunteers / Counselors do not sell, recommend, or endorse any specific insurance product, agent, company, Medicare Advantage Plan, or Prescription Drug Plan nor may they be actively affiliated with the insurance industry, financial planning industry, or pharmaceutical industry. Any potential conflict of interest will be clearly disclosed to you.
- Volunteers / Counselors will seek from you any and all information necessary to provide comprehensive counseling assistance and you acknowledge that the information provided by the counselor will be based upon the accuracy and completeness of the information provided by you.
- Volunteers / Counselors will use information collected only in pursuit of assisting you and will not divulge confidential data to external sources other than Medicare, service providers, or insurance carriers in conjunction with counseling or assistance duties.
- Upon your request, the volunteers / counselor will assist you with applications for and enrollment into health care benefits, including Medicare Prescription Drug Coverage, and premium assistance programs. The decision to enroll in or apply for a specific health care benefit or insurance coverage is solely your choice. Assistance provided by the counselor will be to follow the application/enrollment instructions and fill in the application/enrollment form with information provided directly you. Any Information provided by you during the process is assumed to be complete, truthful and accurate.
- Volunteers / Counselors assume no responsibility for decisions made or actions taken by you and you agree to hold harmless the Montana State Health Insurance Assistance Program, Missoula Aging Services or other Montana Medicare Advocacy organizations, and the volunteer / counselor for any liability arising out of services provided within the program guidelines.

☐ I agree and understand to the provisions and guidelines of the Montana State Health Insurance Assistance Program (SHIP) or Adult Resource Alliance of Yellowstone County.

Please sign (type) your name: _____

Date:_____

PLEASE SIGN AND RETURN THIS FORM EVERY YEAR.