Area Agency on Aging of the Capital Area

ship state health insurance assistance programs NATIONAL NETWORK

Pre-Enrollment Form

MEDICARE OPEN ENROLLMENT
October 15th to December 7th

Once Completed, Return This Form To:
Area Agency on Aging of the Capital Area
6800 Burleson Road, Bldg. 310, Suite 165, Austin TX 78744
Fax (512) 916-6042

Name: **Date of Birth:**

Address:

City: **State:** **Zip:**

Phone: **County:** **Year-Round Resident?** ☐ Yes ☐ No

Email Address:

How did you hear about us: **Primary Language?**

I am interested in reviewing my Part D Drug Plan? ☐ Yes ☐ No **Advantage Plan?** ☐ Yes ☐ No

Do you have a Supplement? ☐ Yes ☐ No **Are you happy with your supplement?** ☐ Yes ☐ No

Do you currently have other insurance coverage? ☐ Yes ☐ No **If yes, Which?** _____

I need help for: ☐ Open Enrollment ☐ Initial Enrollment ☐ Special Enrollment ☐ Other _____

Medicare Card Information

Name:

Number:

Part A effective Date:

Part B effective Date:

I need a new Medicare Card? ☐ Yes ☐ No

MyMedicare.gov Account Info

☐ **I Prefer NOT to share this Information**

Username:

Password:

Security Question:

Answer:

Income/Subsidy Information

Do your monthly income fall below $1,561 for Single or $2,114 for Married couple? ☐ Yes ☐ No

Do your Resources/Assets fall below $12,890 Single or $25,720 Married? ☐ Yes ☐ No

Are you currently receiving? ☐ Extra Help

☐ Medicaid ☐ QMB (Medicare Savings Plan)

Pharmacy Information

What is your Preferred Pharmacy? _____

Alternative Pharmacy? _____

Do you use Mail Order? ☐ Yes ☐ No

Are there any Medications that are not covered by your current plan? ☐ Yes ☐ No

List: _____

Please provide us with information about your prescriptions.

NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach.
If not, please complete the chartbelow. Please attach additional sheets if needed.

Name of Drugs	Strength	Daily Dose
Example: Lipitor	*Example: 10 mg.*	*Example: Twice Daily*

Do you have any problems, comments or concerns you would like to discuss?

Appointment Preferences:

I prefer ☐ Mornings ☐ Afternoons What time works best for you?

I would prefer to have a ☐ Phone Appointment ☐ Video Chat ☐ I can only meet in person

Have you ever participated in a video conference before? ☐ Yes ☐ No

I prefer to use ☐ Zoom ☐ Google Meets ☐ Go2Meeting ☐ Other

I have a computer at my home that I can use? ☐ yes ☐ no

I am comfortable with the computer ☐ yes ☐ no

I have internet at my home ☐ Yes ☐ No I have an active email account? ☐ Yes ☐ No

FOR OFFICE USE ONLY:

Appointment Scheduled for: Date:_____ Time: _____

☐ Phone ☐ Video ☐ In-person Sent Comps, Materials, Link ☐ Mail ☐ Emailed ☐ Fax Date_____

Area Agency on Aging of the Capital Area
Consumer Rights & Responsibilities for Older Americans Act Programs

The Area Agency on Aging of the Capital Area welcomes you as a participant in programs for older individuals and family caregivers in our region. This program is mandated by the Older Americans Act of 1965, as amended, and provides access and assistance and other supportive services. The programs and services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, consumer contributions and local funding.

Programs and services are designed for individuals age 60 or older and/or their family members and other caregivers. Our goal is to assist older individuals in leading independent, meaningful and dignified lives in their own homes and communities as long as possible through the provision of limited support services. Information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

Consumer rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

Patty Bordie
Director of Aging Services
Area Agency on Aging of the Capital Area
6800 Burleson Rd., Bldg. 310, Ste. 165
Austin, Texas 78744

4. You have the right to participate in the development of a care plan to address unmet needs.
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding.
6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available and change service providers when desired.
7. You have the right to be informed of any change in service(s).
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized.
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold harmless this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies for any liability arising out of the services provided in accordance with program guidelines.

_____ _____

X Consumer Signature X Date

Area Agency on Aging of the Capital Area
Consumer Information Release Form

Consumer Name:	**Date:**
By signing this authorization, you are giving the Area Agency on Aging of the Capital Area (AAACAP) permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the AAA. This release includes access to a continuum of service(s) available through the AAA or its providers.	

PARTS A, B & C TO BE COMPLETED BY CONSUMER OR PERSONAL REPRESENTATIVE

I authorize the Area Agency on Aging to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

PART A – Release of Information
I understand that my information may contain protected health information. Release my information to the following person or agency:
☐ Any person or agency necessary to meet my service needs.
☐ Only the persons or entities identified:
Check one of the following: ☐ Release all of my information. ☐ Release only the following information:

PART B – Purpose of Release
☐ General: To assist in assessing, arranging, and meeting individual service needs.
☐ Specific:
Expiration: This authorization expires at point of reassessment, where applicable, or within three years of effective date.

PART C – Signature	
(Consumer or Personal Representative)	**(Date)**
☐ Check if you are signing for the consumer and please describe your authority to act for the consumer on the following line:	
NOTE: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the consumer's file.	
Witness:	Date:
Witness:	Date:

Notice to Consumer:

- Once the authorization to release your information is granted, the AAA is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given the AAA to use or disclose health information that identifies you, unless the AAA has already taken action based on your permission. You must withdraw your permission in writing.