Date: ________________

Referral to APD

Please call ____(site), ________________________(phone number) for an appointment to help you with the following:

Medicare Premium Assistance

___ Part A

___ Part B

___ Both Part A&B

Services

___ Services eligibility determination

Other (Explain)

____

____

Information that APD might find useful:

____

____

(Indicate if individual has applied for a program but eligibility has not yet been determined.)

Other Medicare Information:

If enrolled in a Part D Plan—

Name of Plan __________________________ Effective Date_______________

If enrolled in a Medicare Advantage Plan—

Name of Plan __________________________ Effective Date_______________

If enrolled in a Medicare Supplement (Medigap) Plan—

Name of Plan __________________________ Effective Date_______________

If applied for / enrolled in a Limited Income Subsidy (LIS)—

Application Date ________________________ Effective Date_______________

SHIBA Counselor _______________________________________

Counselor phone________________________ Email _________________________________