

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 _____