Henry County Senior Center
OSHIIP/Benefit Assistance Programs

Please print clearly:

Name: _____ Date of Birth _____/_____/_____

Address: _____

Phone Number: _____ Current Medicare Drug Plan_____

Medicare Claim Number _____-_____-_____

Effective Dates: Part A ____/____/____ and/or Part B ____/____/____

Do you currently have coverage with: _____ Original Medicare or _____ Medicare Advantage

If enrolled in Medicare Advantage plan, what is the plan name _____

Check to see if you qualify for "Extra Help" to pay for some of your prescription costs

Single: Income $1,581 per month; Total Resources $14,390

Married: Income $2,134 per month; Total Resources $28,720

Please list the name of your prescribed medication(s) you take currently, the dosage and the 30-day quantity. You can attach a printout of your current medications from your pharmacy or you can write them in below.

Preferred Pharmacy: _____

Drug Name	Dosage	30 Day Quantity

I, _____, hereby acknowledge and agree that information, guidelines, and suggestions provided to me by the Henry County Senior Center in connection with its OSHIIP/Benefit Assistance Program do not constitute legal advice on any issue, and that any and all consequences, legal or otherwise, of any action taken in connection with my application or non-application for MediGap, Medicare Advantage, Medicare Part D Drug coverage, Social Security Extra Help, Medicare Savings programs and/or other state programs are solely, completely and fully my responsibility. I therefore hereby release, discharge, and agree to forever hold harmless the Henry County Senior Center and its employees, agents, representatives, and volunteers from any and all claims, complaints, charges, demands, causes of action, or asserted liability of any kind whatsoever arising in connection with my assistance for enrollment or non-enrollment and application provided by the OSHIIP/Benefit Assistance program in Henry County.

_____ ____/____/_____

Signature Date