



Mail to: ServiceLink Resource Center
30 International Drive Suite 202
Portsmouth, NH 03801

LOCAL HELP FOR PEOPLE WITH MEDICARE

2015 PART D WORKSHEET
PLEASE PRINT

Name _____

Address _____

Phone # _____ Date of Birth _____

Medicare Number _____

Effective Dates Part A _____ Part B _____
(These are under the claim number on your red, white and blue Medicare card.)

Mail comparison Call me to schedule an appointment Planfinder Workshop

In order for us to know if you may be eligible for extra help with your Part D, please check one of the following:

I am single and my income is under \$1471/mo **AND** my assets are under \$12,140

I am married and our combined income is under \$1991/mo **AND** our assets are under \$27,250

I already receive extra help with Part D I do not qualify for extra help

Name of Your Current Plan: _____

Preferred Pharmacy _____

Are you a Veteran? Yes No

MY MEDICATIONS: I can use low-cost generics Yes No I don't know

If you need more space, please use the other side and check here

Please do not send printouts from the pharmacy.

Name of Medication	Strength / Milligrams	How many do you take a day?

Office Use Only

Received: _____ Initial _____ Appointment Date/Time: _____

Mailed: _____ Initial _____

Subsidy None Full Partial: 25% 50% 75%

Saved ID# _____ Password _____
Date _____

