

Nelson County Community Clinic

300 West John Fitch Avenue, Suite 200

Bardstown, KY 40004

P (502) 349-5990 F (502) 349-5993

2026 MEDICARE PLAN FINDER APPLICATION

NAME: _____

AGE: _____ RACE: _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP CODE: _____ EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____

PHONE NUMBER: _____

PRIMARY CARE DOCTOR: _____

PHARMACY: _____

Do you have a separate Supplemental Health Insurance Policy (Medigap)
to your Medicare B Plan? Yes No _____

Current Rx Drug Plan: Yes No _____

• DO YOU HAVE END STAGE RENAL DISEASE? (ESRD) Yes No

• DO YOU HAVE LOU GEHRIGS DISEASE (ALS) Yes No

7. What is your marital status?

Married Single Widowed Divorced

8. What type of plan are you looking for?

Medicare Advantage (A plan that covers health care and prescription drugs)

Medicare Prescription Drug Plan (A plan that covers only prescription drugs)

9. Did you receive a letter from Medicare or Social Security that said you are either eligible for or qualified for Extra Help paying for your Medicare Prescription Drug Plan costs? Yes No

If no, answer questions 10 and 11 if you think you would like our office to assist you in applying for Extra Help.

10. What is your monthly income for you and everyone in the household before deductions and list the source (*social security, disability, etc.*)

11. What are your resources? *Bank Accounts (amount in checking and savings) CD's, Stocks, Bonds, Savings Bonds, Mutual Funds, IRA's, Cash in home, or other similar investments:*

- Value of Real Estate other than your home: _____

12. Please select up to two pharmacies:

- First choice: _____

- Street address: _____

- City: _____ State: _____ Zip Code: _____

- Second Choice: _____

- Street address: _____

- City: _____ State: _____ Zip Code: _____

ATTACH A LIST OF YOUR MEDICATIONS OR FILL OUT THE FORM BELOW

INHALERS - HOW MANY USED PER MONTH? _____

INSULIN - HOW MANY PENS/BOTTLES USED PER MONTH? _____

DO NOT INCLUDE OVER THE COUNTER MEDICATIONS

	DRUG NAME <i>(Example) LIPITOR</i>	MG <i>80 mg</i>	DOSAGE <i>2 daily</i>	QUANTITY <i>(30 Days)</i>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				

→ CONTINUE TO NEXT PAGE IF NEEDED

MEDICATIONS CONTINUED.....

	DRUG NAME <i>(Example) LIPITOR</i>	MG <i>80 mg</i>	DOSAGE <i>2 daily</i>	QUANTITY <i>(30 Days)</i>
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
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Bardstown, Kentucky 40004
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e-mail: bjohnson@bardstown.com

Medicare Benefits Counseling Program

Signature Waiver

I, _____
(PRINT NAME)

hereby authorize Nelson County Community Clinic Medicare Benefits Counseling Staff to research and assist me in comparing Medicare Insurance Plans and coverage. All information provided is true to the best of my knowledge.

Client Address

Client Signature Date

Authorized Program Representative Date