

Senior LinkAge Line®

Client Contact Sheet

Staff/Volunteer Name:

Date: _____

1. Beneficiary Information

Name: _____
Address: _____
City/State/Zip/County: _____
Home Phone: _____ Work Phone: _____ Email: _____
DOB or Age: _____ Male Female Ethnicity: _____
Is this a couple: Yes No If yes, Spouse's Name: _____ DOB or Age: _____
Language spoken if not English: _____
Beneficiary is under 65 and receiving Social Security Disability: Yes No
Beneficiary has: Physical disabilities Alzheimer's/Dementia Both

2. Call/Contact Made By – Complete if call or contact made by anyone other than self: If Self, go to 4.

Beneficiary/Self: _____ Couple: _____ Caregiver (family member, conservator, etc): _____ Agency: _____
Name: _____
Organization: _____
Address: _____
City/State/Zip/County: _____
Home Phone: _____ Work Phone: _____ Email: _____ Fax: _____

3. If Caregiver, relationship to beneficiary: Adult/Child/Relative Friend/Neighbor Spouse/Partner

Does Caregiver live with Care Receiver? Yes No Grandparent Raising Grandchild? Yes No

4. How heard about us?

Brochure Called before Church Dining Site Drug Company Flyer/Poster Kiosk Mailing
MBA Medicare Newsletter Newspaper Other Agency Pharmacy Phonebook
Physician/clinic Presentation Promo Item Radio Senior Center Social Security TV Word of mouth Website Other _____

5. How Contacted Us? SLL Agency Line Email Fax Mail Walk-in Website Other

6. Financial Information

Gross monthly income from all sources. If couple, include spouse's income: \$ _____
Total Assets – from all sources. If couple, include spouse's assets: \$ _____
Medicare FYI client dollars saved: Yes No Amount: \$ _____
Medicaid dollars saved: Yes No Amount: \$ _____
Other Savings: Yes No Amount: \$ _____

7. Eligible for Medicare Savings Program: Yes No Reason not eligible:

Income too high Income/Assets too high Assets too high Income Savings LTC Facility
Not MN Resident Not enrolled in Medicare Other drug coverage Other _____

8. Not applying for Medicare Savings Program: Estate recovery Paper work Stigma

Family discouraged Unknown Other _____

9. Insurance Information

On Medicare – Part A Part B Supplemental Insurance – Yes No
 Medicare Number: _____
 Supplemental Insurance Number: _____

10. Type of assistance: Hang up Info only Information and Referral Info/Ref/Assist

11. Type of Contact	Outbound	Length of Contact
SLL	_____	_____
Telephone	_____	_____
Walk-in	_____	_____
In Person – Site	_____	_____
In Person – Church	_____	_____
In Person – Senior Center	_____	_____
In Person – Library	_____	_____
In Person – Clinic	_____	_____
In Person – Other Non Gov't Setting	_____	_____
In Person – Home	_____	_____
Fax	_____	_____
Email	_____	_____
Postal Mail	_____	_____
Totals	_____	_____

12. Presenting Problem	Need Met	Yes	No	Reason Unmet
Forms Assistance	_____	_____	_____	_____
QMB	_____	_____	_____	_____
SLMB/QI – 1	_____	_____	_____	_____
MN Prescription Drug Program	_____	_____	_____	_____
Manufacture Drug Program	_____	_____	_____	_____
Medicare Approved Discount Card	_____	_____	_____	_____
Medicare Part D	_____	_____	_____	_____
Medicare Preventive Benefits	_____	_____	_____	_____
Medicare Enrollment, Eligibility	_____	_____	_____	_____
Medicare Appeals/Quality Care	_____	_____	_____	_____
Medicare Claims/Billing	_____	_____	_____	_____
Medicare Advantage Enroll, Eligibility	_____	_____	_____	_____
Medicare Advantage Dis-enrollment	_____	_____	_____	_____
Medicare Advantage Chage/Non-renewal	_____	_____	_____	_____
Medicare Advantage Claims/Billing	_____	_____	_____	_____
Medicare Advantage Appeal	_____	_____	_____	_____
Medicare Fraud, Abuse and Waste	_____	_____	_____	_____
Complaint	_____	_____	_____	_____
Complaint referred for follow-up	_____	_____	_____	_____
Complaint resulting in action	_____	_____	_____	_____
Senior Surf Day	_____	_____	_____	_____
Long-Term Care Insurance	_____	_____	_____	_____
Life Insurance	_____	_____	_____	_____
COBRA	_____	_____	_____	_____
Burial Plan	_____	_____	_____	_____
Employer Health Plan/FEHP	_____	_____	_____	_____
Customer Service/Complaint	_____	_____	_____	_____
Medical Assistance	_____	_____	_____	_____
Medical Assistance Fraud and Abuse	_____	_____	_____	_____
Medical Assistance Other (EW, AC)	_____	_____	_____	_____

Minnesota Care	_____	_____	_____
MCHA	_____	_____	_____
Veteran's Administration Benefits	_____	_____	_____
Medigap Enroll/Eligible/Compare	_____	_____	_____
Medigap Change Coverage	_____	_____	_____
Medigap Claims/Appeals	_____	_____	_____
SSI	_____	_____	_____

13. Notes