Oceana County Council on Aging / MMAP
Medicare Prescription Plan Assistance Form

Name_____ Date_____

Medicare Number _____

Effective Date- Part A: _____ Part B:_____

Date of Birth _____ Phone:_____

Address_____

_____

Do you have any current prescription drug coverage? If yes, please check what type of coverage you have:

____Part D Program> Name of Plan _____

____Medicaid ____TRICARE or Veterans ____Employer or Retiree Plan

Other:_____

Do your resources (assets) total **OVER** $11,500 (single) or $23,000 (couple)?
_____Yes _____No (Count savings, checking, CDs, stocks, etc. **Homestead, autos and personal items are **not** counted as assets)

Preferred pharmacies (list 2) and their location:

_____

_____

Please remember to fill out the prescription information sheet included with this form. Drop off all paperwork at the Oceana County Council on Aging, 621 E. Main St. Hart, MI 49420, Monday – Friday between 9 am and 4 pm. Please feel free to call (231) 873-4461 and ask for Vickie or Char if you have any questions.

Please enter your current prescription drug coverage information below:

	Drug Name	**Tablet / Capsule / Liquid or list other type**	**Dosage and amount taken monthly**	**Cost** (regular price, optional)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				