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Human Services Agency - Ventura County Area Agency on Aging
Health Insurance Counseling and Advocacy Program (HICAP)

Comparison-Appointment Request Form

www.vcaaa.org/comparison-form

First Name _____ M.I. _____ Last Name _____

Address _____ City _____ Zip _____

Mailing Address (if different) _____

Birthdate ____/____/____ Telephone (____)____-____ Email _____

Preferred method of contact for appointment: Email Telephone Online Zoom In person

What is the best time to reach you: _____ AM PM

Preferred Language: English Spanish Other: _____

Social History

Marital Status Married Separated Domestic Partner Never Married Divorced Widowed Decline to State

Race African American/Black American Indian/Alaskan Indian Caucasian/White (not Hispanic) Asian Indian

Cambodian Chinese Filipino Guamanian Hawaiian Japanese Laotian Samoan Vietnamese

Not Collected Decline to State Two or More Races Other Race: _____

Ethnicity Hispanic/Latino Not Hispanic/Latino Not Collected Decline to State

The Gay, Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)

What is your gender? Male Female Transgender Female to Male Transgender Male to Female

Genderqueer/Non-Binary Decline to State Missing/Not Collected Not Listed, Please Specify: _____

What was your sex at birth? Male Female Decline to State Missing/Not Collected

How do you describe your sexual orientation or sexual identity? Straight/Heterosexual Bisexual Gay/Lesbian

Questioning/Unsure Decline to State Missing/Not Collected Not Listed, Please Specify: _____

Military Service

Have you ever served in the United States military? No Yes

Are you the spouse, legal partner, parent, or child of a person who is serving, or who has served, in the U.S. military? No Yes

If you answered yes to either of the last two questions, do you consent to this agency and the California Department of Aging transmitting your name, email address, mailing address, and telephone number(s) to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which you may be eligible? I understand that this consent is valid for 12 months from the date of signature. No Yes N/A

Please look at your prescription drug card/health plan card and look for PDP or HMO.

Do you have Medicare Part A? No Yes If yes, enter effective date: _____

Do you have Medicare Part B? No Yes If yes, enter effective date: _____

Do you have a Medicare Stand Alone Part D Plan (PDP)? No Yes If yes, please specify name of plan: _____

Do you have an HMO Medicare Advantage (Plan C)? No Yes If yes, please specify name of plan: _____

Do you receive prescription drug coverage from a retiree, union or employer plan? No Yes

Specify your preferred pharmacy: _____

How did you hear about us?

Another agency (SSA, Medi-Cal, etc.) Aging Into Medicare booklet California Department of Aging

California Health Associates Centers for Medicaid and Medicare Services Friend/Relative Info Van Internet

Mailing Media Outreach Event by HICAP Other: _____

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You may be eligible to save on prescription drug costs and qualify for other programs.

Are you on Medi-Cal? No Yes If no, are you interested in applying? No Yes

If yes, what is your share-of-cost (SOC) amount: _____

Are you receiving Cal Fresh benefits? No Yes If no, are you interested in applying? No Yes

If you are interested in applying, is your MONTHLY GROSS INCOME LESS than \$1,473 for one person or \$1,984 for two people purchasing and preparing food together? No Yes

Are you interested in receiving help paying for your home energy bills, certain repairs, and/or weatherization projects? No Yes

Are your ASSETS (bank and IRA accounts) LESS than \$15,160 if single or \$30,240 if married? No Yes

Is your MONTHLY GROSS INCOME LESS than \$1,823 if single or \$2,465 if married? No Yes

Prescription Drug Information — PLEASE LIST ALL CURRENT PRESCRIPTIONS

Please print clearly. The information you provide will guide our comparison.

TIP: Pull out your medication bottles and transcribe full drug name onto the list below.

	NAME OF PRESCRIPTION DRUG	DOSAGE (how many mg)	HOW OFTEN (# per day/ week/month)	BRAND NAME REQUIRED? (yes/no)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

ATTACH ADDITIONAL SHEETS IF NEEDED

Please indicate the reason why you are requesting an appointment with a HICAP counselor:

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Disclosure Statement

HICAP counseling services are provided by trained counselors, registered by the California Department of Aging, who are acting in good faith to provide independent, impartial information about health insurance policies and benefits to clients. Counselors do not sell any type of health care coverage. They do not endorse or recommend any specific plan or policy. Information presented by HICAP volunteers should not be construed to be legal advice, and volunteers are not liable for acts and omissions in providing counseling to recipients of service. Welfare and Institutions Code, Section 9541 (1)(4)

By signing your name and entering the date below, you acknowledge that you have read and understand this disclosure.

I have read and understand this disclosure.

Electronic Signature/Signature: _____

Type/Print Name: _____ Date: _____

Return completed worksheet by email, mail or fax.

HICAP@ventura.org

Ventura County HICAP
646 County Square Drive, Suite 100, Ventura, CA 93003

Fax: (805) 477-7341

Phone: (805) 477-7300 or (800) 434-0222

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Information for the Medicare Beneficiary

Drug Plan Term	Definition	Application
Premium	Monthly fee plan charges to allow cost-sharing for your prescription drugs.	You may pay the plan directly or have it withheld from Social Security.
Deductible	This is the amount you must pay each year for your prescriptions before your Medicare drug plan pays its share. Deductibles vary between plans. A maximum is set each year.	You pay the negotiated retail price for your drugs until you have met the Plan's Deductible. Many plans waive the Deductible for tier 1 and 2 (generic) drugs.
Tier	Plans have levels or tiers of copayments/coinsurance with different costs for different types of drugs.	Brand drugs are in higher tiers than generic drugs and cost more. Different plans may place the same drug in different tiers affecting the cost.
Not on Formulary	Plan may have negotiated a retail price with the pharmacy. You don't get the benefit of cost-sharing.	You pay the same price January-December in your plan.
Prior Authorization	Plan requires your doctor to tell the plan why this drug is medically necessary.	You and/or your prescriber can contact the plan to request an exception.
Quantity Limits	Plans may limit the amount of prescription drugs they cover over a certain period of time.	If your prescriber believes that, because of your medical condition, a quantity limit isn't medically appropriate, you or your prescriber can contact the plan to ask for an exception.
Step Therapy	In most cases, you must first try a certain, less expensive drug on the plan's formulary that's been proven effective for most people with your condition before you can move up a "step" to a more expensive drug.	If your prescriber believes it's medically necessary for you to be on a more expensive step therapy drug without trying the less expensive drug first, you or your prescriber can contact the plan to request an exception.

Reference: medicare.gov

It is the mission of the Health Insurance Counseling & Advocacy Program (HICAP) to provide accurate and objective counseling, advocacy, and assistance with Medicare, health insurance, managed care, long-term care, and related health coverage plans for Medicare beneficiaries, their representatives, or persons imminent of Medicare eligibility, and to educate the public on Medicare and health coverage issues.

DISCLAIMER: HICAP counseling services are provided by counselors, registered by the California Department of Aging, to provide information to help you make informed, independent decisions about your health insurance needs. Counselor may not make the decision for you and may not make specific recommendations or referrals. Much of the information provided to you will be provided to the counselor by other government agencies or companies. The Area Agency on Aging and its employees and volunteers disclaim any responsibility for the accuracy of any such information provided. The counselors assisting you are acting in good faith to provide information about health insurance policies and benefits. This information shall not be constructed as legal advice, and the counselors are, generally, not liable for acts and omissions in providing counseling to recipients of this service.

