Senior LinkAge Line®
Client Contact Sheet for In-Person Visit

Staff/Volunteer Name*_____

Date of Contact* ___/___/____ Site Name:_____ Total Time*:_____

Basic Information (*= required)

First Name*:_____ **Last Name***:_____ Spouse's Name:_____

Address 1*:_____ Address 2:_____

City*:_____**State***:_____ **Zip***:_____**County***:_____

Home phone*:_____ Work Phone: _____ Email: _____

DOB*:_____ **Gender***:_____ Spouse's DOB:_____ Spouse's Gender:_____

Ethnicity* (check all that apply):

☐American Indian/Alaskan Native	☐Asian Indian	☐Black, African American
☐Chinese	☐Filipino	☐Guamanian or Chamorro
☐Hispanic, Latino or Spanish Origin	☐Japanese	☐Korean
☐Native Hawaiian	☐Other Asian	☐Other Pacific Islander
☐Samoan	☐Some other race/ethnicity	☐Vietnamese
☐White		

Language spoken if not English_____

Living Situation:

☐Friend/Relative	☐Halfway House	☐Homeless	☐Own Home
☐Renter, Market Rate	☐Renter, Subsidized	☐Long-term Care Facility	☐Other
☐Housing w/ Services, Assisted Living			

Currently Living With:

☐Alone	☐Child	☐Group Setting	☐Parents - Child
☐Parents - Adult	☐Spouse/Partner and Others	☐Spouse/Partner Only	☐Other

Marital Status: ☐Divorced ☐Married ☐ Single ☐Partner/Significant Other ☐Separated ☐Widowed

Employment Status: ☐Full-time ☐Not Employed ☐Part-Time ☐Self-employed ☐Temporary

Privacy and Release:

Data Privacy Info Given*: ☐Yes ☐No

Signed Privacy Notice Received*: ☐Yes ☐No

SLL Outreach Survey Given*: ☐Yes ☐No

Contact Made By, if other than consumer:

Call/Contact made by (specify):_____

Name/Organization _____

Relationship to Consumer:_____ Address_____

City/State/ZIP/County_____

Home Phone _____Work Phone _____Email _____Fax: _____

Does Caregiver Live with Care Receiver? ☐Yes ☐No

How Heard about SLL:*

☐2-1-1	☐AARP	☐Adult Day Center	☐Advocate
☐Assisted Living	☐Billboard	☐Brochure	☐Called Before
☐Case Manager	☐Ctr. for Indep. Living	☐Conference/Fair	☐County
☐Cty. Vet. Service Officer	☐Dept. of Commerce	☐Dept. of Human Services	☐Dining Site
☐Disability Linkage Line®	☐Employer	☐Flyer/Poster	☐Friend/Neighbor
☐Good Age	☐Health Care Choices	☐Health Plan	☐Home Health Care
☐Hospital	☐Kiosk	☐Legal Services	☐Legislator
☐Library	☐Mailing	☐Medicare	☐MinnesotaHelp.info
☐Newsletter	☐Newspaper	☐Ombudsman	☐Pharmacy
☐Physician/Clinic	☐Place of Worship	☐Presentation	☐Radio
☐Social Security	☐Television	☐Veterans Linkage Line	☐Website

☐Other (specify):_____

Where Assistance Provided:*

☐Area Agency on Aging	☐Clinic	☐Comm.Center	☐County Office	☐Edu. Facility
☐Emergency Room	☐Asst. Living	☐Other Campus	☐Own Home	☐Hospital
☐Library	☐Work Force Ctr.	☐Nursing Home	☐Place of Worship	☐Sr. Center
☐Living at Home/ Block Nurse Program	☐Other (specify):_____			

Financial Information:

Gross Monthly Income: $_____

If couple, spouse's income: $_____

Income FPL*:

☐At or Above 150% FPL ☐Below 150%

FPL Assets: $_____

If couple, spouse's assets: $_____

Asset FPL*:

☐Above LIS Asset Limit ☐Below LIS Asset Limit

Number in Household:_____

Federal Benefits:

Social Security Number:_____ SSDI Start Date (If applicable):____/____/_____

Medicare Number:_____ **Start Dates**: Part A___/___/_____ Part B___/___/_____

Medicare Part C: ☐Cost Plan ☐Local HMO ☐PFFS ☐RPPO ☐SNBC ☐SNP

Medigap Coverage (Please Specify):_____

Medicare Part D Plan:_____ **ID Number**:_____

LIS Level: ☐1 (Full LIS/Higher Copays) ☐2 (Full LIS/Lower Copays) ☐3 (Full LIS/$0 Copays) ☐4 (Partial LIS)

General Disability Information:

Beneficiary is under 65 and receiving Social Security Disability: ☐Yes ☐No

Beneficiary has(✓ all that apply): ☐Physical disabilities ☐Alzheimer's/Dementia ☐Mental Illness

Specific Disability Information:_____

MSP/LIS Information:

Eligible for Medicare Savings Program: ☐Yes ☐No ☐Already Enrolled

Reason Not Eligible:
☐Assets Too High ☐Income and Assets Too High ☐Income Too High ☐Long-Term Care Facility
☐Not a MN Resident ☐Not Enrolled in Medicare ☐Other_____

Eligible for Low Income Subsidy (LIS): ☐Yes ☐No ☐Deemed

Reason not applying for MSP/LIS:
☐Creditable Drug Coverage ☐Estate Recovery ☐Family Discouraged ☐Other Benefits Reduced
☐Paperwork ☐Stigma ☐Too confusing
☐Other_____

Minnesota Benefits:

Medical Assistance (MA):
☐Emergency Medical Assistance (EMA) ☐Medical Assistance (MA) ☐MA with Spenddown
☐Medical Assistance for Employed Persons with Disabilities (MA-EPD) ☐MA Long-term Care

Other MN Health Care Programs:
☐Alternative Care (AC) ☐Program HH ☐MinnesotaCare ☐Non-Citizen Medical Assistance (Program NM)
☐Other_____

Waiver: ☐Yes ☐No

Medical Assistance (MA) Number/Person Master Index (PMI):_____

Managed Care Plan:_____ **Type of Managed Care:**_____

Veterans Benefits:

Veteran: ☐Yes ☐No

Remember: If consumer identifies self as veteran, ask about current veteran's benefits and inform of other veteran's benefits that may be an option.

RxConnect:

Given Medication Management Sheet: ☐Yes ☐No **Given RxConnect Packet:** ☐Yes ☐No

Number of Applications Completed:_____ **Estimated Rx Cost Savings:** $_____

Medication Information:
Prescription Drug #1_____ Dosage:_____ Quantity:_____
Prescribing Doctor's Name:_____

Prescription Drug #2_____ Dosage:_____ Quantity:_____
Prescribing Doctor's Name:_____

For additional drugs add a separate sheet of paper.

Fraud and Abuse:

Complaint against:_____
Address:_____ City/State/ZIP:_____
Phone:_____

MSN Claim #:_____ **Date of Service**:___/___/_____
Provider Number:_____
Appeal Filed: ☐Yes ☐No

Primary Issue: ☐Benefits ☐Enrollment/Eligibility ☐Errors/Abuse ☐Fraud

Topics Discussed (Check all that apply- at least one*)

Medicare Part A
- Eligibility ☐
- Enrollment ☐
- Benefits Counseling ☐
- Claims/Billing ☐
- Appeals/Grievances ☐
- Fraud and Abuse ☐
- Quality of Care ☐

Medicare Part B
- Eligibility ☐
- Enrollment ☐
- Benefits Counseling ☐
- Claims/Billing ☐
- Appeals/Grievances ☐
- Fraud and Abuse ☐
- Quality of Care ☐
- Preventive Benefits ☐

Medicare Part D Prescription Drug Coverage
- Eligibility ☐
- Benefits Counseling ☐
- Plan Enrollment ☐
- Change Plans ☐
- Plan Comparison ☐
- Claims/Billing ☐
- Appeals/Grievances ☐
- Fraud and Abuse ☐
- Marketing Sales Complaints ☐
- Quality of Care ☐
- Plan Non-Renewal ☐

Medicare Advantage
- Eligibility ☐
- Enrollment ☐
- Benefits Counseling ☐
- Claims/Billing ☐
- Appeals/Grievances ☐
- Fraud and Abuse ☐
- Quality of Care ☐
- Plan Comparison ☐
- Marketing/Sales Complaint ☐
- Plan Non-Renewal ☐

Extra Help/LIS
- Appeals ☐
- Application Assistance ☐
- Benefits Counseling ☐
- Claims/Billing ☐
- Loss of LIS ☐

Other Prescription Drug Assistance
- Union/Employer Plan ☐
- Manufacturer Programs ☐

Medicare Supplement/SELECT

- Eligibility
- Enrollment
- Benefits Counseling
- Claims/Billing
- Appeals/Grievances
- Fraud and Abuse
- Quality of Care
- Plan Comparison
- Marketing/Sales Complaint
- Plan Non-Renewal

Medical Assistance/Public Programs

- QMB Eligibility
- SLMB Eligibility
- QI Eligibility
- MSP Application Assistance
- Medical Assistance Eligibility
- MA Application Assistance
- Claims/Billing
- Fraud and Abuse
- MinnesotaCare

- Alternative Care
- Burial Plan
- Caregiver Supports
- COBRA
- Congregate Dining
- Customer Services Complaint
- Elderly Waiver
- Emergency Assistance
- Employer Health Plan/FEHP
- Food Support
- Foreclosure
- Home Delivered Meals
- Life Insurance
- Long Term Care Insurance
- Long-term Care Partnership
- MN Comp. Health Assoc. (MCHA)
- Rental Assistance
- Senior Surf Day
- SSI
- Tax Preparation
- Telemarketing/Mail/Email Scam
- Utility Assistance
- Veterans Benefits

Notes:

Follow-Up (If Required):

Health Care Choices Given: ☐Yes ☐No

Number of Contacts Out:_____

Drug List ID#:_____ **Password Date:**_____

Confirmation # if application completed*:_____

Medication List

Medication Name	Dosage	Quantity

Type of Service

☐General Information and Assistance ☐Detailed Assistance – In Progress
☐Detailed Assistance – Fully Completed ☐Problem Solving/Problem Resolution – In Progress
☐Problem Solving/Problem Resolution – Fully Completed