Client Contact Record

Statewide Health Insurance Benefits Advisors (SHIBA)

1. Volunteer Information

VOLUNTEER INFORMATION

Organization:* ______ **Counselor:*** ______

COUNSELING INFORMATION

Date of contact:* ______ **Counseling site Zip Code:*** ______

Type of contact:* ◯ Email/fax /postal mail ◯ In-person (home visit staff only) ◯ In-person (site) ◯ Quick call (<10 min.) ◯ Telephone

Time spent:* Hours ______ Minutes 00 ◯ 15 ◯ 30 ◯ 45 ◯

CCR DETAILS

CCR status:* ◯ Closed ◯ Open **Close date:** ______

What type of issue is this?:* ◯ General Information and Referral ◯ Problem Solving ◯ Detail Assistance

Referred to outside agency:
◯ Another state's DOI ◯ Department of Labor ◯ IRS ◯ Other ______
◯ AOA ◯ DSHS ◯ Medicaid ◯ Other state agency
◯ Attorney General ◯ Health Care Authority ◯ Medicare ◯ TRICARE
◯ CMS ◯ HHS/CCIIO ◯ OPM ◯ VA

2. Client Information

CONTACT INFORMATION

Assistance was requested by:*
◯ Agency/social services
◯ Caregiver/legal rep
◯ Daughter
◯ Father
◯ Grandchild
◯ Grandparent
◯ Mother
◯ Other
◯ Other family
◯ Provider
◯ Self/client
◯ Significant other/ domestic partner
◯ Son
◯ Spouse

Specify other: ______

How did you hear about SHIBA?:*
◯ CMS Medicare
◯ DSHS
◯ Friend/relative
◯ Health fair
◯ Mailing
◯ Medical/dental provider
◯ Newspaper (name)
◯ Other
◯ Other Internet/ website
◯ Pharmacist
◯ Poster
◯ Radio (name)
◯ Returning client
◯ SHIBA presentation
◯ SHIBA publication
◯ SHIBA/OIC website
◯ Social Security Administration
◯ Social service agency (name)
◯ TV (name)
◯ Not collected

Specify other: ______

REPRESENTATIVE

Name: ______ **Phone type:** ◯ Home phone ◯ Cell phone ◯ Work phone

Email: ______ **Phone number:** ______ **Ext:** ______

CLIENT INFORMATION

Client name: ______ **Address:** ______

City: ______ **State:*** ______ **Client Zip:*** ______

Client county:* ______ **Email:** ______

2. Client Information continued

CLIENT INFORMATION (continued)

				Preferred contact number
Work phone:		**Ext:**		◯
Home phone:				◯
Cell phone:				◯

3. Client Eligibility

CLIENT DEMOGRAPHICS

Gender:* ◯ Male ◯ Female

Age:* ◯ 0 – 19 ◯ 20 – 30 ◯ 31 – 40 ◯ 41 – 50 ◯ 51 – 64 ◯ 65 – 74 ◯ 75 – 84 ◯ 85+ ◯ Not collected

Race/ethnicity:* ◯ American Indian or Alaska Native ◯ Asian ◯ Black/African American ◯ Hispanic/Latino ◯ Some other race ◯ Native Hawaiian or other Pacific Islander ◯ White/not Hispanic origin ◯ Other ______ ◯ Not collected

Primary language: (If other than English) ◯ ASL ◯ Cambodian ◯ Cantonese ◯ Korean ◯ Mandarin ◯ Russian ◯ Spanish ◯ Tagalog ◯ Vietnamese ◯ Other ______

Interpreter needed: ◯ Yes ◯ No

CLIENT ELIGIBILITY

Disabled:* ◯ Yes ◯ No ◯ Not collected — Receiving or applying for Medicare Disability or Social Security Disability

Dual eligible with mental illness/ mental disability:* ◯ Yes ◯ No ◯ Not collected

Veteran: ◯ Yes ◯ No ◯ Not collected

Enrolled Tribal member: ◯ Yes ◯ No ◯ Not collected

CLIENT HOUSEHOLD INFORMATION

FAMILY SIZE: Number of relatives living in home, including client: ______

HOUSEHOLD

Household monthly income before taxes

◯ $0 – $908
◯ $909 – $1,226
◯ $1,227 – $1,362
◯ $1,363 – $1,816
◯ More than $1,816
◯ Not collected

Household estimated assets

◯ Up to $3,000 SSI-Related
◯ Up to $10,020 MSP
◯ Up to $25,260 LIS
◯ More than $25,260 Other
◯ Not collected

INDIVIDUAL

Individual monthly income before taxes

◯ Below 150% FPL
◯ At or Above 150% FPL
◯ Not collected

Individual estimated assets

◯ Up to $2,000 SSI-Related
◯ Up to $4,000 MSP
◯ Up to $12,510 LIS
◯ More than $12,510 Other
◯ Not collected

4. Topics Discussed

INSURED CURRENTLY ◯ Yes ◯ Yes (Losing insurance within the next 12 months) ◯ No

- ☐ ~~Basic Health~~
- ☐ CHIP
- ☐ COBRA
- ☐ Discount plan
- ☐ Employer group plan
- ☐ Individual insurance
- ☐ Medicaid
- ☐ Medicare (Part A)
- ☐ Medicare (Part B)
- ☐ Medicare Health Plan (Part C)
- ☐ Medicare Rx (Part D)
- ☐ Medigap
- ☐ Military/TRICARE/TRICARE for Life
- ☐ Veterans/CHAMPVA
- ☐ WA State Health Insurance Pool (WSHIP)
- ☐ Other ________

TOPICS DISCUSSED *At least one topic from Medicare or non-Medicare topics must be selected.

Medicare topics discussed: Age 65 and older or Medicare related:

◯ Yes ◯ No

Medicare dollars saved:

☐ Yearly estimated dollars saved $ ________

Medicare Parts A and B:

- ☐ Appeals/complaints
- ☐ Claims/billing
- ☐ Enrollment/eligibility/benefits

Medicare Health Plans/Advantage (Part C)

- ☐ Appeals/complaints
- ☐ Claims/billing
- ☐ Enrollment/eligibility/comparisons
- ☐ Plan/benefit changes/non-renewals

Prescription Drug Assistance/Medicare Rx (Part D)

- ☐ Appeals/complaints
- ☐ Claims/billing
- ☐ Enrollment/application assistance
- ☐ Low-Income Subsidy (LIS)
- ☐ Plan eligibility
- ☐ WA State Rx Discount Card

Medigap/Supplements

- ☐ Appeals/complaints
- ☐ Changing coverage
- ☐ Claims/billing
- ☐ Enrollment/eligibility/comparisions

Medicaid

- ☐ Medicaid (COPES, aged, blind, disabled)
- ☐ Medicare Savings Program (QMB/SLMB/QI-1)

Other prescription assistance

- ☐ Discount cards/assistance plan
- ☐ Union/employer plan
- ☐ Other ________

Other

- ☐ Claims/billing
- ☐ COBRA
- ☐ Customer service issues/complaints
- ☐ Dental
- ☐ Employer plan
- ☐ Fraud/abuse
- ☐ Health Savings Accounts
- ☐ Long term care
- ☐ Military/TRICARE/TRICARE for Life
- ☐ Social Security Disability
- ☐ Tribal health benefits
- ☐ Veterans/CHAMPVA
- ☐ WA State Health Insurance Pool (WSHIP)
- ☐ Other ________

Non-Medicare topics discussed: Age 65 and not Medicare related:

◯ Yes ◯ No

Non-Medicare dollars saved:

☐ Yearly estimated dollars saved $ ________

Low-income assistance

- ☐ ~~Basic Health~~
- ☐ CHIP
- ☐ Free or low-cost clinics
- ☐ Medicaid (children's)
- ☐ Medicaid (family, pregnant, alien)

Other prescription assistance

- ☐ Discount cards/assistance plan
- ☐ Union/employer plan
- ☐ Other

Other

- ☐ Claims/billing
- ☐ COBRA
- ☐ Customer service issues/complaints
- ☐ Dental
- ☐ Dependent coverage
- ☐ Employer plan
- ☐ Fraud/abuse
- ☐ Health Savings Accounts
- ☐ Individual /insurance options
- ☐ Long term care
- ☐ Medical Savings Program
- ☐ Military/TRICARE/TRICARE for Life
- ☐ Social Security Disability
- ☐ Tribal health benefits
- ☐ Veterans/CHAMPVA
- ☐ WA State Health Insurance Pool (WSHIP)
- ☐ ~~Washington Health Program~~
- ☐ Other

5. Complaint Information

COMPLAINT INFORMATION

Is this a complaint?: ◯ Yes ◯ No

Do you want OIC to take action:* ◯ Yes, client understands his/her name may be used and has consented
◯ No, for tracking purposes only

COMPANY AND PLAN DETAILS

Company name:* ____________________

Plan name: ____________________ **Medicare #:** ____________________ **Policy #:** ____________________

Agent/broker name: ____________________ **Agent/broker phone:** ____________________

COMPLAINT DETAILS

Nature of complaint*

- ☐ Access to care
- ☐ Access to insurance
- ☐ Agent handling/misrepresentation
- ☐ Alleged/potential fraud
- ☐ Benefits change/reduction
- ☐ Billing error/overcharged
- ☐ Claim denied
- ☐ Coverage
- ☐ Dependent coverage
- ☐ Enrollment/disenrollment issues
- ☐ Inadequate provider network
- ☐ Insurance cancellation
- ☐ Misinformation/false claims
- ☐ Plan non-renewal
- ☐ Premium billing withholding
- ☐ Premium increase
- ☐ Quality of care
- ☐ Other ____________________

◯ Yearly estimated dollars saved $ ____________________

Action taken to date: ____________________

What action would the client like to see happen?: ____________________

6. Notes