THE SHINE PROGRAM
Serving the Health Insurance Needs of Everyone

Pre-Appointment Form 2025/2026

APPOINTMENT DATE: _____
TIME: _____
LOCATION: _____

MEDICARE OPEN ENROLLMENT October 15th thru December 7th 2025

Return This Form To: **SHINE@mves.org**
Mystic Valley Elder Services | SHINE Program
300 Commercial Street, Malden, MA 02148

Name: **Date of Birth:**

Address:

City: **State:** **Zip Code:**

Phone: **County:** **Year-Round Resident?** ☐ Yes ☐ No

Email Address:

How did you hear about us: **Primary Language?**

I am interested in reviewing my: ☐ Part D Drug Plan ☐ Advantage Plan ☐ Changing Coverage
Name of Current Plan (if applicable): _____ **Current Plan Monthly Premium:** _____
Do you have a Medigap Supplement? ☐ Yes ☐ No
Do you currently have other insurance coverage? If yes, what type of coverage? _____

I need help for: ☐ Open Enrollment ☐ Initial Enrollment ☐ Special Enrollment ☐ Other _____

Medicare Card Information

Name:

Number:

Part A effective Date:

Part B effective Date:

I need a new Medicare Card? ☐ Yes ☐ No

Medicare.gov Account Info

User Name:

Password:

Security Question:

Answer:

Income/Subsidy Information

Does your monthly income fall below $2,935 for Single or $3,966 for Married couple? ☐ Yes ☐ No

Do you receive ☐ Extra Help ☐ MSP ☐ MH

Pharmacy Information

Your Preferred Pharmacy? _____

Alternative Pharmacy? _____

Do you use Mail Order? ☐ Yes ☐ No

Any and all information provided on this form is completely optional and provided solely at your discretion.

Please provide us with information about your prescriptions and pharmacy.

NOTE: You may be able to obtain a computerized listing from your pharmacist/pharmacy to attach.

If not, please complete the chartbelow. Please attach additional sheets if needed.

Specify if brand name is mandated; otherwise, all prescriptions are for generics

Name of Drugs	Strength/Form	Dosage
Example: Lipitor	*Example: 10 mg. tablet*	*Example: 1/day; 3 vials/month*

Do you have any problems, comments or concerns you would like to discuss?

Appointment Preferences: Do you already have an appointment set up with SHINE? ☐Yes ☐No

I prefer ☐ **Mornings** ☐ **Afternoons** **What time works best for you?**

I would prefer to have a ☐ **Phone Appointment** ☐ **Video Chat** ☐ **Email**

Have you ever participated in a video conference before? ☐ **Yes** ☐ **No**

I prefer to use ☐ **Zoom** ☐ **Other**

I have a computer at my home that I can use? ☐ **Yes** ☐ **No**

I am comfortable with the computer ☐ **Yes** ☐ **No**

I have internet at my home ☐ **Yes** ☐ **No** **I have an active email account?** ☐ **Yes** ☐ **No**

FOR OFFICE USE ONLY:

Appointment with: Counselor's Name _____ **Agency:** _____

☐ **Phone** ☐ **Video** ☐ **In-person Sent Comps, Materials, Link** ☐ **Mail** ☐ **Emailed** ☐ **Fax Date**_____