Medicare Client Needs Assessment
Email: info@medicare-planning.com
Fax: (785) 783-5326
Full Name: _____ Phone: _____

Date Of Birth: _____ Referred by: _____

Full Address: _____

Email: _____ Medicare ID/Number: _____

1. Do you currently have (Part A and/or Part B)? _____
    a. If you do have Part A, what date did it start? _____
    b. If you do have Part B, what date did it start? _____
2. Do you currently have a Medicare Supplement Plan **OR** Medicare Advantage Plan? _____
    a. If so, what Supplement Plan do you have or what Medicare Advantage Plan Do you currently have? _____
    b. If so, what is your current monthly premium? _____
    c. If so, why did you pick that particular Medicare Supplement OR Medicare Advantage Plan?

        _____

        _____
3. Do you have a history of **Cancer**, **Heart attack** or **Stroke** in your family? _____
4. Have you had a family member use home health care or go into a nursing home? _____
    a. If so, how did **they** pay for it?_____
    b. How would **you** pay for it? _____
5. Do you currently carry Life Insurance? _____
    a. What is the **Death Benefit?** _____ What is your **premium?** _____ What is the **Cash value?** _____
    b. If you have life insurance, what purpose does it serve for you and your family?
        Income replacement **Final expenses** **Outstanding debts** **Help family financially**
6. Have you made any arrangements to take care of final expenses? _____
7. Are you satisfied with the present rate of return on your investments? _____
    a. Are you dealing with the stock market OR the bank? _____
    b. Do you have a 401k / 403B / 457? _____ If YES, what did you roll it into?

        _____
8. Would you like to have us quote insurance for your **Home** , **Auto** , **Boat**, etc to see if we can save your some premium dollars in addition to insuring you have proper coverage?_____
    a. If YES, please provide your most current **Declaration pages** for your Home, Auto, Boat, etc. **AND Driver's license Number** by Email or FAX or regular mail.
9. Would you also like quotes for **Dental** / **Vision** and **Hearing Insurance**? _____
10. Who else (family, friends...etc) do you think could benefit from learning about their options for Medicare (i.e Medicare Supplement, Medicare Advantage, Part D Prescription Drug) ?

    _____

    _____
11. Do you currently have a Long-Term Care (LTC) Policy in place? _____
    a. If YES, would you like it reviewed? _____
    b. If NO, would you like for us to quote options for you? _____

Medicare Client Needs Assessment
Email: info@medicare-planning.com
Fax: (785) 783-5326

Medication List

Pharmacy Preference's _____
Current Drug Plan: _____

(Please add additional pages if needed)

List your current prescriptions. Please include drug name, dosage in milligrams (MG) tablet or capsules and quantity that you take per month

Brand/Gen	Name of RX	Dosage/MG	Tabs/Caps	Quantity per month

Comments / Concerns:

_____

_____