Plan Finder Worksheet
Medicare Open Enrollment 2027

Golden Crescent Aging and Community Services (ACS)

Full name: (as it appears on Medicare Card)		
Address:		
Mailing:		
Phone:	*Email:*	*DOB:*
11-digit Medicare number:		
Plan A Effective Date:	*Preferred Pharmacy:*	
Current Plan:	*Are you Interested in mail order pricing?* ☐*YES* ☐ *NO*	

I am requesting:	☐	*Part D Prescription Plan Comparison*	☐	*Medicare Advantage Comparison*	☐	*Unsure*	
I would like for my premium to be:			☐	*Deducted*	☐	*Billed*	
Do you receive any of the following programs?	☐	*QMB*	☐	*SLMB or QI*	☐	*Extra Help*	☐ *None*
Is your monthly income under $2,015 for a signle person, or $2,725 for a couple?					☐	*Yes*	☐ *No*

Medication	Dosage	Frequency

☐ I give consent for Golden Crescent Area on Aging Benefits Counselors to assist me with my Medicare Comparison using the above information; I understand that a Medicare.Gov account may be created for me to assist in this process.

Sign: _____ Date: _____