



2026 HEALTH COVERAGE INFORMATION

Today's Date _____

Name: _____ Physical Address: _____

City: _____ Zip Code: _____

Mailing Address (if different from physical address): _____

City: _____ Zip code: _____

Phone #: _____ Alternate Phone #: _____ E-mail: _____

Medicare Number: _____ Date of Birth: _____

Medicare effective dates: **Part A** ___/___/___ **Part B** ___/___/___

Medi-Cal	Yes	No
Retiree Plan	Yes	No
Employer Plan	Yes	No
Tricare	Yes	No
VA Benefits	Yes	No

Marital Status: _____

Ethnicity: _____



Name of current Prescription Plan or Medicare Advantage Plan:

Pharmacy Name: _____

Phone Number: _____

Do you receive your prescriptions via Mail Order? Yes: ☐ No: ☐ Both: ☐

Would you like to see Mail Order prices in your comparison? Yes: ☐ No: ☐

1. What is your Gender?
☐ Male ☐ Female
☐ Transgender Female to Male
☐ Transgender Male to Female
☐ Genderqueer/Gender Non-binary
☐ Not Listed, Please specify:

☐ Decline/Not Stated

2. What was your sex at birth?
☐ Male
☐ Female
☐ Decline/Not Stated

3. How do you describe your sexual orientation or sexual identity?
☐ Straight/Heterosexual
☐ Bisexual
☐ Gay/Lesbian/Same-Gender Loving
☐ Questioning/Unsure
☐ Not Listed. Please specify:

☐ Decline/Not Stated

Did someone help you complete this form? Yes: ☐ No: ☐
 Name: _____
 Relationship: _____
 Phone Number: _____

You must also complete the back of this worksheet

Kern County Aging & Adult Services, Health Insurance Counseling & Advocacy Program (HICAP)

5357 Truxtun Avenue, Bakersfield, CA 93309

661-868-1000 or 1-800-434-0222

Drug Name (Provide FULL name as it appears on the label)	If you take Brand Name, can you substitute with Generic? Yes or No	Dosage and Drug Form (Tablet, Capsule, Drops, cream, etc.)	Frequency (How many you take per day)
Example: Atropine Diphenoxylate ER		2.5-0.025 MG – TABLET	1 a Day

Disclosure Statement: HICAP counseling services are provided by trained counselors, registered by the California Department of Aging who are acting in good faith to provide information about health insurance policies and benefits to you, the client. This information shall not be construed to be legal advice, and the volunteer HICAP counselor is generally not liable for acts and omissions in providing counseling to recipients of this service. (W&I Code, Section 9541 (f).) If you choose a plan and have difficulty in completing the necessary forms or process for enrollment, the HICAP Counselor will assist you. However, you will be responsible for the actual plan contract. The HICAP Counselor will NOT choose your plan for you.

Read Disclosure Statement and sign here: X _____ Date _____

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**To list additional medications please use a separate sheet of paper and attach it to this form*