Needs Analysis Worksheet

FOR AGENT USE ONLY

Name

Address

City

State

Zip Code

County

Phone

Are you currently covered through your employer? ☐ Yes ☐ No

If yes, do you have out-of-pocket costs? ☐ Yes ☐ No

Premiums? ☐ Yes: ______ ☐ No

Deductibles? ☐ Yes: ______ ☐ No

Co-pays? ☐ Yes: ______ ☐ No

Drug cost shares? ☐ Yes: ______ ☐ No

Medicare Card? ☐ Yes ☐ No

Medicare Part ☐ A ☐ B

Medicaid/MediCal Card? ☐ Yes ☐ No

Current Health/Drug Plan Name

Other drug coverage such as VA, retirement plan, etc.

Preferred Pharmacy

Do you use mail order? ☐ Yes ☐ No

Current PCP

Current Specialist

Hospital Preference

Which is most important to you? ☐ Doctor ☐ Specialist ☐ Hospital

Current Dental Plan

Current Vision Plan

Is transportation provided with your current plan? ☐ Yes ☐ No

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Would you like information on Low Income Subsidy to assist with the cost of your prescriptions? ☐ Yes ☐ No

Do you have any chronic conditions such as Asthma, COPD, Cardiovascular Disease (CVD), Congestive Heart Failure (CHF), Dementia, Diabetes, Hypertension, etc? Explain:

Prescription Name	Strength	Dosage	Brand	Generic
1. Prescription Name			☐	☐
2. Prescription Name			☐	☐
3. Prescription Name			☐	☐
4. Prescription Name			☐	☐
5. Prescription Name			☐	☐
6. Prescription Name			☐	☐
7. Prescription Name			☐	☐
8. Prescription Name			☐	☐
9. Prescription Name			☐	☐
10. Prescription Name			☐	☐