

# State Health Insurance Assistance Program (SHIP) Public and Media Activity Form

**Instructions:** This form is for all SHIP Public and Media Activities. Use one form per activity, which can include in-person presentations, booths/exhibits, or media or internet activities. Definitions of each type of activity are provided

## SECTION 1 - TYPE OF ACTIVITY (Check only one type of activity A-G)

<input type="checkbox"/> <b>A. Interactive presentation to public</b> ♦ In-Person ♦ Video teleconference or satellite broadcast Estimated # of attendees: _____ Estimated # of people enrolled (If any): _____	<input type="checkbox"/> <b>D. Web-site event</b> ♦ Web conference/forum ♦ Interactive chatroom Estimated # of people potentially reached: _____
<input type="checkbox"/> <b>B. Booth/exhibit at health/senior fair, etc.</b> Estimated # of people potentially reached: _____ Estimated # of people enrolled (If any): _____	<input type="checkbox"/> <b>E. TV/cable show (not a PSA or ad)</b> Estimated # of people potentially reached: _____ # times this show re-aired (if known) _____
<input type="checkbox"/> <b>C. Radio show (not a PSA or ad)</b> Estimated # of people potentially reached: _____ # times this show re-aired (if known) _____	<input type="checkbox"/> <b>F. Enrollment Event</b> Estimated # of people enrolled: _____
<input type="checkbox"/> <b>G. Other: _____ (e.g. PSAs, targeted informational mailing, newspaper/newsletter articles)</b> Estimated # of people potentially reached: _____ # times this PSA re-aired/re-printed/etc. (if known) _____	

**H. In-Kind Space Provided**

- Yes** Approximate value of space provided \_\_\_\_\_
- No** \$ \_\_\_\_\_

**Signature** \_\_\_\_\_  
 (of person who donated the space)

## SECTION 2 - ACTIVITY INFORMATION (Please provide the following information if applicable.)

<b>Date of activity:</b> ____ / ____ / ____ month / day / year  <b>Time of activity:</b> Start ____ Stop ____  <b>If multiple dates:</b> ____ / ____ / ____ through ____ / ____ / ____  <b>Total length of activity across all dates:</b> ____ hrs (round to nearest hour)	<b>Event or group name:</b> _____  <b>Location of event:</b> <b>Address:</b> _____ <b>City, State, Zip:</b> _____ <b>County:</b> _____  <b>Name(s) of Presenter(s):</b> _____
<b>Contact Name:</b> _____ <b>Contact Phone:</b> _____	<b>Type of Presenter(s):</b> <input type="checkbox"/> SHIP Staff/coordinator/sponsor <input type="checkbox"/> SHIP Counselor/volunteer <input type="checkbox"/> Other: _____

## SECTION 3 - TOPIC FOCUS (Check all that apply)

<input type="checkbox"/> Medicare (Parts A and B) <input type="checkbox"/> Non-renewal situation <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Medigap/Medicare Supplements <input type="checkbox"/> Fraud & Abuse <input type="checkbox"/> Medicare Prescription Drug Coverage (PDP/MA-PD)	<input type="checkbox"/> Other Prescription Drug Coverage/Assistance <input type="checkbox"/> Medicare Health Plans <input type="checkbox"/> QMB/SLMB/QI <input type="checkbox"/> Other Medicaid <input type="checkbox"/> General SHIP program information <input type="checkbox"/> Other (specific health topics--ESRD, diabetes): _____
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## SECTION 4 - TARGET AUDIENCE (Check all that apply)

<input type="checkbox"/> Medicare beneficiaries and/or pre-enrollees <input type="checkbox"/> Family members/caregivers of Medicare benes. <input type="checkbox"/> Low-income <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White, Not of Hispanic origin <input type="checkbox"/> Disabled <input type="checkbox"/> Rural <input type="checkbox"/> Other (please describe, such as professionals): _____
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