

MEDIA OUTREACH & EDUCATION FORM

*** Items marked with asterisk (*) indicate required fields**

Start Date of Activity *: _____ End Date of Activity: _____

MIPPA Event *: Yes No

Send to SMP:	<input type="checkbox"/> Yes <input type="checkbox"/> No	SIRS eFile ID: (*required if sending record to SMP)	This field will automatically utilize the SIRS eFile ID entered on the Session Conducted By user's SHIP Team Member form
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ACL SMP Consumer Alert (*required if sending record to SMP) Yes No

Event Details *

Session Conducted By *: _____	Partner Organization Affiliation* : _____
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Total Time Spent on Event *: _____ Hours _____ Minutes	Title of Interaction *: _____
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Type of Media * (select only one): <input type="checkbox"/> Billboard <input type="checkbox"/> Radio <input type="checkbox"/> Email <input type="checkbox"/> Social Media <input type="checkbox"/> Magazine <input type="checkbox"/> Television <input type="checkbox"/> Newsletter <input type="checkbox"/> Website <input type="checkbox"/> Newspaper <input type="checkbox"/> Other	Estimated Number of People Reached: _____ Geographic Coverage (select only one): <input type="checkbox"/> County or Counties <input type="checkbox"/> Regional <input type="checkbox"/> Multi-State <input type="checkbox"/> Statewide <input type="checkbox"/> National <input type="checkbox"/> Zip Code
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Event Location *

State of Event * : _____ Zip Code of Event * : _____
 County of Event * : _____

Media Contact Information

Media Contact First Name: _____	Media Contact Phone: _____
Media Contact Last Name: _____	Media Contact Email: _____

Intended Audience * (multiple selections allowed):

<input type="checkbox"/> Beneficiaries	<input type="checkbox"/> Medicare Pre-Enrollees
<input type="checkbox"/> Employer-Related Groups	<input type="checkbox"/> Partner Organizations
<input type="checkbox"/> Family Members/Caregivers	<input type="checkbox"/> Other

Target Beneficiary Group * (multiple selections allowed):

- | | | |
|--|--|--|
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Limited-English Proficiency | <input type="checkbox"/> Rural |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> LGBTQI+ | <input type="checkbox"/> Other |
| <input type="checkbox"/> People with Disabilities | <input type="checkbox"/> Low Income | <input type="checkbox"/> N/A |

Topics Discussed * (multiple selections allowed):

- | | | |
|---|--|--|
| <input type="checkbox"/> Duals Demonstration | <input type="checkbox"/> Medicare Fraud and Abuse | <input type="checkbox"/> Partnership Recruitment |
| <input type="checkbox"/> Extra Help/LIS | <input type="checkbox"/> Medicare Part D | <input type="checkbox"/> Preventive Services |
| <input type="checkbox"/> General SHIP Program Information | <input type="checkbox"/> Medicare Savings Program | <input type="checkbox"/> Substance Misuse/Fraud |
| <input type="checkbox"/> Long-Term Care Insurance | <input type="checkbox"/> Medigap or Supplemental Insurance | <input type="checkbox"/> Volunteer Recruitment |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Original Medicare (Parts A and B) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Medicare Advantage | <input type="checkbox"/> Other Prescription Drug Coverage | |

Special Use Fields

Field 1: _____

Field 2: _____

Field 3: _____

Field 4: _____

Field 5: _____

Notes

Large empty rectangular area for notes.