

**Nebraska Senior Health Insurance Information Program (SHIIP) Public and Media Activity Form**

**Instructions:** This form is for all SHIIP Public and Media Activities. Use one form per activity, which can include in-person presentations, booths/exhibits, media or Internet activities.

**SECTION 1 - TYPE OF ACTIVITY (check only one type of activity A-G)**

<input type="checkbox"/> <b>A. Interactive Presentation to Public</b> <input type="radio"/> In-Person <input type="radio"/> Video Teleconference or Satellite Broadcast Estimated # of attendees: _____ Estimated # of people enrolled (if any): _____	<input type="checkbox"/> <b>D. Website Event</b> <input type="radio"/> Web Conference/Forum <input type="radio"/> 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: _____ Estimated # of people assisted: _____
	<input type="checkbox"/> <b>G. Other:</b> _____ (e.g. PSAs, targeted informational mailing, newspaper/newsletter articles) Estimated # of people potentially reached: _____ # times this PSA re-aired/re-printed/etc. (if known): _____

**SECTION 2 - ACTIVITY INFORMATION (please provide the following information)**

<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	<b>Event or group name:</b> _____  <b>Location of event:</b> <b>Address:</b> _____ <b>City, State, Zip:</b> _____ <b>County:</b> _____
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**Name(s) of Presenter(s):** \_\_\_\_\_

<b>Contact Name:</b> _____ <b>Contact Phone:</b> _____	<b>Type of Presenter(s):</b> <input type="checkbox"/> SHIIP Staff/Coordinator/Sponsor <input type="checkbox"/> SHIIP Counselor/Volunteer <input type="checkbox"/> Other: _____
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**SECTION 3 - TOPIC FOCUS (check all that apply)**

<input type="checkbox"/> Original Medicare (Parts A and B) <input type="checkbox"/> Long-Term Care Insurance <input type="checkbox"/> Fraud & Abuse <input type="checkbox"/> Other Prescription Drug Coverage/Assistance <input type="checkbox"/> QMB/SLMB/QI <input type="checkbox"/> General SHIIP Information <input type="checkbox"/> Dual Eligible (Medicare/Medicaid) w/a Mental Disability	<input type="checkbox"/> Medigap/Medicare Supplement Insurance <input type="checkbox"/> Medicare Prescription Drug Coverage <input type="checkbox"/> Medicare Advantage Plans <input type="checkbox"/> Other Medicaid <input type="checkbox"/> Part D Low-Income Subsidy (LIS) <input type="checkbox"/> Other ( <b>prevention, online tools, health topics</b> ): _____
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**SECTION 4 - TARGET AUDIENCE (check all that apply)**

<input type="checkbox"/> Medicare Beneficiaries and/or Pre-Enrollees <input type="checkbox"/> Low-Income <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White, Not of Hispanic Origin <input type="checkbox"/> Rural <input type="checkbox"/> Dual Eligible (Medicare/Medicaid) w/a Mental Disability	<input type="checkbox"/> Family Members/Caregivers of Medicare Benes <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Disabled <input type="checkbox"/> Other (please describe, such as professionals): _____
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