

SHIBA Media Outreach & Education Form

* Items marked with asterisk (*) indicate required fields

MIPPA Event*: **Send to SMP:** **SIRS eFile ID: (*REQUIRED if sending record to SMP):**

Yes No Yes No

Event Details*

Session Conducted By*:

Partner Organization Affiliation*:

Total Time Spent on Event*:

_____ Hours _____ Minutes

Title of Interaction*:

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 |

Est. 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 |

Start Date of Activity*: _____

End Date of Activity: _____

Event Location*

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

Media Contact Information

First Name: _____

Phone: _____
(_____) _____

Last Name: _____

Email: _____

Intended Audience* (multiple selections allowed):

- | | | |
|--|--|---|
| <input type="checkbox"/> Beneficiaries | <input type="checkbox"/> Limited-English Proficiency | <input type="checkbox"/> People with Disabilities |
| <input type="checkbox"/> Employer-Related Groups | <input type="checkbox"/> Medicare Pre-Enrollees | <input type="checkbox"/> Rural Beneficiaries |
| <input type="checkbox"/> Family Members/Caregivers | <input type="checkbox"/> Partner Organizations | <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"/> Rural |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Languages Other Than English | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Low Income | <input type="checkbox"/> Not Collected |
| <input type="checkbox"/> Disabled | <input type="checkbox"/> Native Hawaiian or other Pacific Islander | <input type="checkbox"/> Other |

Topics Discussed* (multiple selections allowed):

- | | | |
|--|--|---|
| <input type="checkbox"/> Duals Demonstration | <input type="checkbox"/> Medicare Fraud and Abuse | <input type="checkbox"/> Other Prescription Drug Coverage |
| <input type="checkbox"/> Extra Help/LIS | <input type="checkbox"/> Medicare Part D | <input type="checkbox"/> Partnership Recruitment |
| <input type="checkbox"/> General SHIP Program Info | <input type="checkbox"/> Medicare Savings Program | <input type="checkbox"/> Preventive Services |
| <input type="checkbox"/> Long-Term Care Insurance | <input type="checkbox"/> Medigap/ 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 | | |

Special Use Fields

Field 1: _____

Field 2: _____

Field 3: _____

Field 4: _____

Field 5: _____

Notes