

Community Education Request



1. YOUR FACILITY INFORMATION

| | | | | |
|-------------------|-----------------|--------|-------|-----|
| _____ | | | | |
| Agency/Group Name | Date of Request | | | |
| _____ | | | | |
| Contact Name | Position/Title | | | |
| _____ | | | | |
| Telephone | E-Mail | | | |
| _____ | | | | |
| Street | City | County | State | Zip |

2. YOUR AUDIENCE INFORMATION

Please Note: Materials are available in English, Spanish, and Chinese, and at times in Vietnamese and Russian. We may be able to provide a translator, and are happy to work with one of yours.

Service Providers Beneficiaries and Consumers Caregivers

Group Size: _____ Language: _____ Requested Length: _____

Preferred days for presentation: _____

Time of Day: Morning Lunch Afternoon Evening

3. YOUR TOPIC CHOICE

| | | |
|--|---|---|
| <input type="checkbox"/> Medicare Part D | <input type="checkbox"/> Basic Medicare | <input type="checkbox"/> Supplementing Medicare |
|--|---|---|

Please fax this form to
San Mateo County: 650-627-9359

Santa Clara County: 408-249-8918 San Francisco: 415-546-1344

1-800-434-0222