

Community Education Request

1. OUR FACILITY INFORMATION

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

2. OUR 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. OUR TOPIC CHOICE

Medicare Part D
 Basic Medicare
 Supplementing Medicare

Medicare for Those who Continue to Work

*Please Fax this form to
San Mateo County 650-627-9359*

1-800-434-0222