Diabetes Foundation

MEDICATION ASSISTANCE & SUPPORT SERVICES PROGRAM APPLICATION

INSTRUCTIONS: The Diabetes Foundation (DF) assists all New Jersey residents who are unable to pay for diabetes medications and/or supplies due to financial hardship. Our program provides up to sixty days of insulin, oral medication or injectables with applicable supplies. All medications are considered. The DF reserves the right to contact you with follow-up questions prior to the application being approved. Processing of applications takes place M-F 9-5. Once approved, delivery to a participant's doorstep takes 2-7 days. This must be filled out by a healthcare provider. If you are an individual in need of services, please call (201) 444-0337 for more information or bring this to your provider for processing.

APPLICATION REQUIREMENTS:

Forms must be signed by a "Referrer" who can confirm the applicant's financial need (i.e. physician, nurse, social worker, case worker).

- A document displaying proof of NJ residency must be provided (i.e. copy of driver's license, utility bill, phone bill, invoice, hospital face sheet etc.).
- Applicants must be residents of the state of New Jersey in order to receive assistance.
- Prescriptions for each item requested- copies are acceptable
- Please include prescriptions for all testing supplies, including glucometer, syringes, pen needles, test strips, and lancets, as well as any medications including dosing and medication supplies.
- The prescriptions MUST be written for a quantity of 2 months or 60 days and dated within the past 3 weeks of application submission.
- Copies of both sides of the applicant's insurance card(s) if they currently possess private/employer insurance, Affordable Care Act insurance, Medicare, Medicaid etc. (NOTE: This does not disqualify the applicant from the program)
- Once approved, applicant will be contacted directly by our pharmacy to set up delivery.

Applications and Prescriptions Can Be Submitted Via:

Fax: (201) 444-5580 | Mail:
Diabetes Foundation
411 Hackensack Avenue, Floor 7
Hackensack, NJ 07601
Questions? Phone: (201) 444-0337 Web: www.diabetesfoundationinc.org

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MEDICATION ASSISTANCE & SUPPORT SERVICES PROGRAM APPLICATION

All questions with * are required. Application cannot be approved otherwise.

Date: _____

1A. APPLICANT INFORMATION

*Applicant's Name: _____

*Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Prefer Not to Answer

☐Other: _____

*Primary Address: _____Apt. #: _____

*City: _____ *State: _____ *Zip: _____

*County: _____

*Date of Birth: ____ /____ /____ Age: _____

Home Phone Number: _____-_____-_____ *Mobile Phone Number: _____-_____-_____

Email Address: _____

*Race: ☐African American/Black ☐Native Hawaiian/Pacific Islander ☐Caucasian/White ☐Asian

☐American Indian or Alaskan Native ☐Hispanic ☐Latinx ☐Other _____

*Ethnicity: ☐ Hispanic/Latinx ☐ Non-Hispanic/Latinx ☐ Unsure

*Citizenship: *Please note: Citizenship status does not disqualify eligibility from our program; however, it allows us to better assist you in finding long-term assistance.*

☐US Citizen ☐Permanent Resident ☐Temporary Citizen ☐Undocumented

*What is the applicant's highest level of education? ☐Less than High School ☐Some High School

☐High School/GED ☐Some College ☐Associates ☐Bachelors ☐Masters ☐PhD ☐Other: _____

*Preferred Language: ☐English ☐Spanish ☐ Other: _____

*Name of contact if not applicant:

Name/Relationship: _____ *Mobile Phone: _____-_____-_____

*Please confirm that the DF is able to contact the applicant or caretaker directly about their medication or other DF services. ☐Yes ☐No

What is your average household income? *Please note: Income does not disqualify eligibility from our program; however, it allows us to better assist you in finding long-term assistance.*

☐ Under $15,000 ☐ $15,000-24,999 ☐ $25,000-34,999 ☐ $35,000-49,999 ☐ $50,000-74,999

☐ $75,000-99,999 ☐ $100,000-149,999 ☐ $150,000-199,999 ☐$200,000 and above

How many people live in your home?

1 2 3 4 5 6 7 8 9 10 10+

1B. DIABETES STATUS

*Type of diabetes: ☐ Prediabetes ☐ Type 1 ☐ Type 2 ☐ Gestational

*Most Recent Hemoglobin A1c Number: _____ *Most Recent A1c Date: _____

*Applicant's Height: _____ *Applicant's Weight: _____

*Applicant's reason for applying: ☐Uninsured ☐Copay is too high ☐Underinsured

☐Currently unemployed ☐Other: _____

*Reason currently in hospital or dates and reason for any past admissions to hospital:

_____

_____ Date: _____

1C. APPLICANT INSURANCE AND HEALTHCARE DETAILS:

Insurance status does not disqualify an applicant from receiving this service

*Do you have insurance? ☐Yes ☐No

*Are you employed? ☐Yes ☐No

*Are you a veteran? ☐Yes ☐No

*Applicant under care of primary physician? ☐No ☐Yes Doctor's Name: _____

Name of Clinic/Office _____

Phone/Email: _____

*Applicant under care of endocrinologist? ☐No ☐Yes Doctor's Name: _____

Name of Clinic/Office _____

Phone/Email: _____

Please indicate applicant's status for the following programs:

	Approved/Current Holder	Does Not Qualify	Application Denied	Application Pending	(If Pending) Date Submitted
MEDICAID	☐	☐	☐	☐	☐
PAAD OR SENIOR GOLD	☐	☐	☐	☐	☐
MEDICARE Currently Hold Which Part(s)? _____	☐	☐	☐	☐	☐
VETERAN (VA) COVERAGE	☐	☐	☐	☐	☐

PHARMACEUTICAL COMPANY PATIENT ASSISTANCE Company Name(s): _____ _____	☐	☐	☐	☐	☐
OTHER (340b at FQHC, Private Insurance etc.): _____	☐	☐	☐	☐	☐

-OR- The applicant does not qualify for any of the above programs because:

_____

_____

1D. DIABETES ANCILLARY SERVICES:

*The DF can provide additional free services to support better health and diabetes self-management including the following. Please check off other services we can assist with:

☐Transportation
☐Health Insurance
☐Food
☐Utility Support
☐Housing
☐Diabetes Education (Nutrition, Activity, Monitoring, Problem Solving)
☐Support Group

*Is applicant experiencing any additional stressors other than financial: ☐Emotional ☐Physical ☐Diabetes Management ☐Powerlessness ☐Hypoglycemia ☐Negative Social Perception ☐Eating ☐Physician ☐Family/Friend ☐Regimen ☐Interpersonal ☐Other: _____

APPLICANT CERTIFICATION

I (applicant's full name) _____ verify that the information provided on this application is true and accurate. I authorize the Diabetes Foundation to use this information to assess my eligibility for participation in the medical assistance program. I understand that this assistance will provide up to 60 days of medications and supplies for one time only. I certify that I do not have the ability to pay for medications at this time and that I am in the process of applying to programs for which I may be eligible for assistance. I understand that it is at the discretion of the Diabetes Foundation that each application is approved. I authorize the Diabetes Foundation, to contact me, or my health care professional, to follow up on my progress. I give permission to my

health care professional to disclose my personal information, including protected health information, to the Diabetes Foundation. as it relates to this request. I understand that the Diabetes Foundation may redisclose my confidential information for the purposes of this program. I acknowledge that the Diabetes Foundation is by the Health Insurance Portability and Accountability Act (HIPPA) and will protect my confidential information and comply with all applicable federal and state laws.

_____ _____

Signature of Applicant Date

2A. REFERRER AND PHYSICIAN INFORMATION

*Referrer Name: _____ *Job Title: _____

*Professional Type: ☐Social Worker ☐CDE ☐RN/APN ☐Physician ☐Other _____

*Facility Name: _____

Department and Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____- _____ - _____ Fax: _____-_____-_____

*Email Address: _____

*Will you personally be assisting the applicant in obtaining long-term/permanent medication assistance? ☐YES ☐NO

☐ I have instructed this applicant to work with the Diabetes Foundation to gain access to long-term medication.

2B. PHYSICIAN INFORMATION

*Name of Physician/Practitioner Writing Prescriptions: _____

*Facility Name: _____

Department and Address:_____

City: _____ State: _____ Zip Code: _____

Telephone: _____- _____ - _____ Fax: _____-_____-_____

2C. APPLICATION RATIONALE

Use the space below to explain the applicant's circumstances. Why is patient requesting assistance?

_____

_____

_____

_____

*2D. HOW DID YOU HEAR ABOUT OUR PROGRAM?

☐ Healthcare Professional (Hospital Personnel, Doctor or Pharmacist)

☐ Google Search

☐ Social Media (Facebook/Twitter/Instagram/Linked-In)

☐ Non-Profit or Government Agency

☐ School

☐ Other _____

3. REFERRER CERTIFICATION

I (referrer's name) _____ certify that the applicant being referred is in financial need and will truly benefit from the medication assistance program. I have explained that the program is a short-term supply of diabetes medications and supplies, and cannot be renewed or refilled. I also certify that I have sent applications or provided information for long-term assistance to the programs indicated in Section V, unless otherwise stated.

_____ _____

Signature of Referrer Date