Diabetes Foundation

SUPPLY ASSISTANCE & SUPPORT SERVICES PROGRAM APPLICATION

INSTRUCTIONS: The Diabetes Foundation (DF) assists uninsured and underinsured New Jersey residents who are unable to pay for diabetes supplies due to financial hardship. DF's Supply Assistance Program is an, emergency service that will be provided for up to sixty days to bridge the gap until a long-term solution can be obtained. DF also maintains a toll-free support network, which is available to supply recipients and others who may have questions or need ongoing resources for obtaining prescriptions, medical care, daily diabetes management, and more. 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 4-7 days. If you need assistance filling this application, please call (201) 444-0337.**

APPLICATION REQUIREMENTS:

- A document displaying proof of address 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.
- A document displaying proof of need must be provided (i.e. unemployment documentation, tax return citing no insurance, healthcare professional letter explaining need etc.).
- Prescriptions required for syringes, pen needles, Omnipod pods, Freestyle Libre Sensors and Dexcom Transmitter and Sensors- copies are acceptable.
- 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)

Incomplete applications will be held until al required documents have been provided

- Each application will be reviewed on a case-by-case basis so that DF can determine the most effective way to assist the applicant for the short-term, as well as the long-term. In some situations, applicants may be deemed as better qualified to speak directly with one of our Diabetes Resource solutions prior to receiving supplies.

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

SUPPLIES

APPLICATION REQUIREMENTS:

Below is DF's preferred supply list. If your patient cannot use the below items, we encourage you to still apply

Test Strips:
- Arkray Glucocard Vital
- Arkray Glucocard Expression
- ReliOn Prime
- ReliOn Premier
- Contour Next
- GenUltimate (compatible with OneTouch Ultra, Ultra 2 and UltraMini)
- One Touch Verio
- Accu-chek Guide
- Accu-chek Smartview
- FreeStyle Lite
- FreeStyle
- True Metrix

Insulin Syringes/Pen Needles:
- BD Syringes
- BD Ultra-Fine Pen Needles

Pods/Sensors:
- Omnipod pods (receiver not included)
- Dexcom Transmitter and Sensors (receiver not included)
- Abbott FreeStyle Libre Sensors (receiver not included)

Other:
- Microlet Lancets
- General Lancets
- Lancing Device
- Alcohol Swabs
- Glucose Tablets

PRESCRIPTION REQUIREMENTS (only needed for pen needles, syringes, Omnipod pods and CGM sensors and transmitter):

- Please make sure to write prescriptions for a 60 day or 2-month supply so DF can provide 2 months of supply assistance.
- Medical Facility can fax prescriptions directly to 201-444-5580
- Pictures and copies of prescriptions are accepted
- Please make sure prescriptions are up to date; we will not accept prescriptions past 3 weeks of date written on prescription

Diabetes Foundation

SUPPLY ASSISTANCE & SUPPORT SERVICE

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 supplies 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: _____

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: _____

*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. SUPPLY INFORMATION

Please check all supplies that you are requesting.

***Note: Prescriptions are required for all syringes, pen needles, sensors, transmitters and pods.*

How many times per day do you test your blood sugar? _____

How many times per day do you use insulin? _____

- ☐ Glucometer
- ☐ Arkray Glucocard Vital Test Strips
- ☐ Arkray Glucocard Expression Test Strips
- ☐ ReliOn Prime Test Strips
- ☐ Contour Next Test Strips
- ☐ One Touch Ultra, Ultra 2 or UltraMini Test Strips (Genultimate)
- ☐ One Touch Verio Test Strips
- ☐ Accu-chek Guide Test Strips
- ☐ Accu-chek Smartview Test Strips
- ☐ FreeStyle Lite Test Strips
- ☐ FreeStyle Test Strips
- ☐ True Metrix Test Strips
- ☐ Dexcom Transmitters and Sensors (Does Not Include Device)
- ☐ Abbott FreeStyle Libre Sensors (Does Not Include Device)
- ☐ Omnipod Pods (Does Not Include Device)
- ☐ Syringes

- ☐ Pen Needles
- ☐ Glucose Tablets
- ☐ Alcohol Swabs

Other_____

_____

_____

4. 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 for the supply program. I understand that this assistance will provide diabetes supplies for one time only. I certify that I do not have the ability to pay for diabetes supplies 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