TRANSPORTATION
PROGRAM APPLICATION

Program Details and 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 Transportation Program is a one-time roundtrip service to assist in getting to and from a healthcare appointment. 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.

ALL APPLICATIONS REQUIRE THE FOLLOWING:

- 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.

Incomplete applications will be held until all 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.

Diabetes Foundation

APPLICATION FOR

A1c SCREENING SERVICES

DATE OF APPLICATION: _____

I. HOW DID YOU HEAR ABOUT US?

- ☐ Healthcare Professional (Hospital Personnel, Doctor or Pharmacist)
- ☐ Google Search
- ☐ Social Media (Facebook/Twitter/Instagram/Linked-In)
- ☐ Non-Profit or Government Agency
- ☐ School
- ☐ Other _____

II. APPLICANT CONTACT & DEMOGRAPHIC INFORMATION

Applicant's Name: _____

Gender: ☐ Male ☐ Female ☐ Prefer Not To Answer

Primary Address: _____ Apt. #:_____

City: _____State: _____ Zip: _____ County:_____

Date of Birth: _____/_____/_____ Age: _____

**Phone Number: _____-_____-_____

**Email Address: _____

***** Mandatory for medication delivery and follow up***

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other: _____

If applicant does not speak English, is there someone else we may contact about their application?

Name/Relationship: _____

Phone: _____-_____-_____

Race/Ethnicity:

☐ African American ☐ Pacific Islander ☐ Caucasian ☐ American Indian or Alaskan Native

☐ Asian ☐ Hispanic ☐ Latino ☐ Other _____

Citizenship:

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

□ US Citizen □ Permanent Resident □ Other _____

Medical Information:

Please check diabetes type that best describes the applicant:

□ Prediabetes □ Type 1 □ Type 2 □ Gestational #_____weeks pregnant

III. NEED INFORMATION

Reason for Application:

- I cannot drive because of healthcare issues
- I cannot drive due to financial issues
- Other: _____

To process your application DF needs proof of New Jersey residency. Please select which will be attached to this application:

- Copy of driver's license
- Copy of government issued ID
- Copy of utility bill
- Face sheet from hospital
- Other: _____

IV. APPOINTMENT INFORMATION

Please let us know where you need to go

- ○ A1C appointment
- ○ Endocrinologist appointment
- ○ Primary Physician appointment
- ○ Podiatrist Appointment
- ○ Certified Diabetes Educator appointment
- ○ Dietitian appointment
- ○ Other _____

Date of Appointment: _____/_____/_____

Doctor or Location Address:

Street: _____ Apt. #:_____

City: _____State: _____ Zip: _____

V. EXPLANATION OF PROGRAM AND 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 roundtrip transportation one time only. I certify that I do not have the ability to access transportation 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 not specifically bound by the Health Insurance Portability and Accountability Act (HIPPA) or the regulations communicated thereunder, but that the Foundation makes reasonable efforts to protect my confidential information and comply with all applicable federal and state laws.

_____ _____

Signature of Applicant Date

Applications Can Be Submitted Via:
Fax: (201) 444-5580 | Email: info@diabetesfoundationinc.org | Mail
Diabetes Foundation
411 Hackensack Avenue, Floor 7
Hackensack, NJ 07601
Questions? Phone: (201) 444-0337 Web: www.diabetesfoundationinc.org