MEDICATION ASSISTANCE & SUPPORT SERVICES

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 medications and/or supplies due to financial hardship. DF's Medication 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 medication recipients and others who may have questions or need ongoing resources for obtaining prescriptions, medical care, daily diabetes management, and more. **Approval takes anywhere from 1-3 days. Delivery takes anywhere from 2-7 days.**

IF YOU ARE AN INDIVIDUAL IN NEED OF THIS SERVICE PLEASE

BRING THIS TO YOUR DOCTOR FOR PROCESSING

ALL APPLICATIONS REQUIRE THE FOLLOWING:

- 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)

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. **In some situations, applicants may be deemed as better qualified to speak directly with one of our Diabetes Resource Solutions specialists prior to receiving medications.**
Once approved, applicant will be contacted directly from our partnered pharmacy to set up a residential delivery of medication and supplies.

MEDICATIONS & SUPPLIES:

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

Insulin:

- Apidra - Vial & Solostar Pen
- Admelog - Vial & Solostar Pen
- Humalog - Vial or QwikPen
- Novolin N, R or 70/30 Vial
- Lantus- Vial or Solostar Pen
- Toujeo Solostar Pen

Insulin Syringes/Pen Needles:
(Please indicate sizes on prescriptions)

- BD Syringes-1cc, 0.5cc or 0.3cc
- BD Ultra-Fine Pen Needles

Testing and Other Supplies:

- Dexcom Sensors & Transmitters
- Omnipod Pods (not including PDM)
- FreeStyle Libre Sensors
- True Metrix Glucometer
- True Metrix Test Strips
- Generic Lancets

In an effort to help underserved applicants please consider using the most affordable brands of insulin, supplies, and testing products. This will allow applicants to access products that can afford and ensure they can remain compliant with their testing and medication regimen.

Prescription Instructions:

- **Please make sure to write prescriptions for a 60 day or 2-month supply so DF can provide 2 months of medication assistance.**
- **Please make sure ALL supplies have prescriptions**
- **For Insulin Users: If possible, please note on prescription if vial and pens can be interchangeable**
- **Once approved for medication assistance by DF, our medication assistance staff will contact the Referrer to now send the patients prescriptions to our partnered pharmacy (in some cases)**

***** Note: Prescriptions MUST be sent to DF with the application for approval. Once approved Referrer will be provided with the pharmacy's direct fax number (if needed)**

Diabetes Foundation

APPLICATION FOR

MEDICATION ASSISTANCE & SUPPORT SERVICES

DATE OF APPLICATION: _____

I. HOW DID YOU HEAR ABOUT OUR PROGRAM?

- ☐ Healthcare Professional (Hospital Personnel, Doctor or Pharmacist)
- ☐ DF Event
- ☐ DF Email
- ☐ DF Social Media (Facebook/Twitter/Instagram/Linked-In)
- ☐ Google Search
- ☐ COVID-19 Testing Site -- if so, please state location _____
- ☐ County/Town Correspondence -- if so, please state location_____
- ☐ Snap-Ed/Community Food Bank – if so, please state location _____
- ☐ 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: _____-_____-_____ Alt. Phone Number: _____-_____-_____

**Email Address: _____

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

Please attach proof of NJ residency/address confirmation

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 _____

III. REFERRER INFORMATION

Referring party must represent a medical or social services organization and must attest to the applicant's financial need.

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: _____

** ***Email address is mandatory for approval of application***

Will you be assisting the applicant in securing long-term/permanent medication assistance?

□ YES □ NO

IF NO, will the applicant be referred to another agency or program for further assistance?

Please state where: _____

IV. APPLICANT MEDICAL INFORMATION & PRESCRIPTION DATA

Please check diabetes type that best describes the applicant:

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

Most Recent Hemoglobin A1c: _____

Age of Diagnosis: _____ Applicant's Height: _____ Applicant's Weight: _____

Allergies to Medications: □ Yes □ No

If Yes, please list: _____

Other medical conditions, diagnoses, recent procedures, etc.:

_____

_____

_____

Please list all prescribed medications and supplies that you are requesting for the applicant.

This section should match the prescriptions provided.

Please be mindful of using more affordable medications and supplies when appropriate.

****Note: Prescriptions are required for all items, including needles and testing supplies.**

	YES	NO	NAME OF PRESCRIPTION/DOSAGE/FREQUENCY
Insulin □ **Vials** □ **Pens**			Brand/Dosage: _____ We may need to interchangeably substitute pens or vials based on dosing. Is this acceptable? _____
Syringes			Syringe Size: _____
Pen Needles			Needle Size: _____
Test Strips			Tests _____ times per day
Lancets			
Glucometer/ Lancing Device			*Patient will receive True Metrix unless otherwise noted
Oral Medications			
Glucagon Emergency Kit (Children Only)			
Other Medications/Supplies			

V. NARRATIVE

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VI. FOLLOW-UP INFORMATION

Please indicate applicant's status for the following programs. Submitting applications for short-term assistance from the DF and longer-term assistance simultaneously ensures that the applicant will never be without their diabetes medication and supplies.

	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.): _____ _____	☐	☐	☐	☐	☐

IF APPLICANT HAS SOME TYPE OF INSURANCE/PRESCRIPTION COVERAGE, PLEASE LIST THE FOLLOWING DETAILS (Note: This will not disqualify eligibility from the program. **Copies of both sides of the applicant's insurance card(s) must also be included.)

PLAN ID #_____ GROUP #_____

RX BIN #_____ RX PCN #_____

MEDICARE CLAIM #_____

INSURANCE CARRIER/HMO_____

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

_____

_____

_____

_____

VII. PHYSICIAN INFORMATION

Name of Physician/Practitioner Writing Prescriptions: _____

Facility Name: _____

Department and Address:_____

City: _____ State: _____ Zip Code: _____

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

**Email Address: _____

** ***Email address is mandatory for approval of application***

Will this physician/practitioner be the primary treating physician? □ YES □ NO

If NO, please indicate which physician/clinic will be providing ongoing medical treatment:

Name of Physician/Practitioner and/or Clinic: _____

City: _____ State: _____

VI. 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

VIII. 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 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 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

☐ Check here to receive text messages regarding other **free** programs offered by the Diabetes Foundation

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