Diabetes Foundation

TRANSPORTATION PROGRAM APPLICATION

INSTRUCTIONS: The Diabetes Foundation (DF) assists uninsured and underinsured New Jersey residents who are unable to pay for transportation to a medical appointment 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. 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, you will be contacted. If you need assistance filling out this application, please call (201) 444-0337. This transport service is provided by Lyft Concierge. The vehicles are not wheelchair accessible.**

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.

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.

Applications and Prescriptions Can Be Submitted Via:

Fax: (201) 444-5580 | Mail:
Diabetes Foundation
45 Whitney Road 2M
Mahwah, NJ 07430
Questions? Phone: (201) 444-0337 Web: www.diabetesfoundationinc.org

Diabetes Foundation

TRANSPORTATION 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 this transportation or any 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

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

_____

_____ Date: _____

1C. 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:**

☐ 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: _____

2. NEED INFORMATION

Reason for Application:

I cannot drive due to health 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: _____

3. 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: _____/_____/_____

Time of Appointment: _____

Doctor or Location Address:

Street: _____ Apt. #:_____

City: _____State: _____ Zip: _____

Telephone: _____- _____ - _____

*3A. 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 _____

4. 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 transportation 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