

# **APPLICANT INFORMATION – PLEASE PRINT**

MEDICAL INFORMATION         Do you have any known allergies/drug reactions?      Yes         If yes, please name the drug(s):      Yes         List prescription medication(s) you are now taking which were not received from Central Pharma         List Over-the-Counter medication(s) you are now taking:         Please check if you have any of the health conditions listed below:		
(Must be a street address.)       Telephone         City       County       State         I am presently a Florida resident. 1 intend to remain a resident of Florida.       Yes         I have diabetes and require insulin. (Prescription attached.)       Yes         I do not have Medicaid or health insurance that covers insulin, or I have       Yes         an insurance co-pay or deductible I cannot afford.       Yes         My annual net family income is \$	Client I.D. Male or Female	
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Applicant Signature Date		

## ELIGIBILITY DETERMINATION: TO BE COMPLETED BY CHD – CHECK THE APPLICABLE BOX BELOW

I certify that based on the information provided by the applicant and according to Chapter 64F-18, F.A.C., this applicant

 $\bot$  is eligible for the Insulin Distribution Program.

is eligible for the Insulin Distribution Program as a current client with an annual net family income at 101% to 200% of the Federal poverty guidelines, that meets all of the other eligibility criteria, has no resources to purchase insulin, and no other source can be found for his/her insulin. This client shall be charged a fee for the insulin based on a sliding fee scale as set forth in Chapter 64F-16, F.A.C.

is not eligible for the Insulin Distribution Program.

Signature of CHD Employee

Date of Eligibility Determination

Date of Eligibility Expiration (one year from determination date)

### EMERGENCY ISSUANCE: TO BE COMPLETED BY CHD

This applicant is not eligible for the Insulin Distribution Program but has declared that he/she does not have the resources to purchase insulin. No other source can be found for his/her insulin; therefore this applicant is eligible to receive a one-month emergency supply of insulin at no cost, one time within a 12-month period.

Signature of CHD Employee

Date

#### DIABETES SELF-MANAGEMENT EDUCATION (DSME) CLIENT REMINDER

CHD staff are encouraged to use the opportunity presented while determining eligibility for the Insulin Distribution Program to ask the client if he/she has attended a DSME class. If the client has not attended a class, CHD staff should provide the client with information on classes available in or near the county. This information can be obtained at <a href="http://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html#Florida">http://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html#Florida</a> or <a href="http://www.diabetes.org/erp\_zip\_search.aspx">http://www.diabetes.org/erp\_zip\_search.aspx</a>

# INSTRUCTIONS TO COMPLETE THE INSULIN DISTRIBUTION PROGRAM APPLICATION FORM

APPLICANT INFORMATION: Assist the applicant in completing the information in this section. It may be necessary to read or explain this section to the applicant.

A prescription that includes the following information must be attached to this form:

- Person's name (printed or typed)
- Person's date of birth
- Practitioner's state license number and DEA number if applicable
- Practitioner's name (printed or typed)
- Practitioner's signature

**ELIGIBILITY CRITERIA:** Determine the applicant's eligibility based on the criteria below:

- Is a self-declared resident of Florida
- Has diabetes
- Is uninsured, lacking insurance that covers insulin, or has an
  insurance deductible or copay that the applicant cannot afford
- Has a net family income at or below 100% of the poverty guidelines

- Practitioner's phone number
- Date of prescription
- Type of insulin (R Regular, N-Intermediate, or 70/30)
- Medication dosage
- Whether and how many refills are allowed
  - Has no more than \$2,500 in private funds, bank accounts, or assets other than a homestead
- Is not a current Medicaid recipient

The CHD will determine eligibility in accordance with their written procedures. The CHD may require documentation of income or accept self-declaration in accordance with local policy. Self-declaration of Florida residency, insurance status, and assets is acceptable.

If the CHD has an on-site pharmacy, the CHD will retain the original application form.

If the CHD does not have an on-site pharmacy, mail the original application and prescription to:

DH 2105-CHP-11/2013

Central Pharmacy 116-A Hamilton Park Drive Tallahassee, FL 32304 (850) 922-9036 or (800) 554-4584