FLORIDA DEPARTMENT OF HEALTH

Insulin Distribution Program Application

APPLICANT INFORMATION

Name: _____ _____
(Please Print) Last First Client I.D.

Address: _____ _____
Street Address/P.O. Box Date of Birth

_____ _____ _____ _____
City State Zip Date

I am presently a Florida resident. I intend to remain a resident of Florida.

I do not have health insurance or the health insurance I have does not cover insulin.

My annual net family income is $_____ and there are _____ people in my family.

My assets, other than my homestead, are below $2,500.

I acknowledge that all information provided by me is true to the best of my knowledge. I understand if I have a change in income or assets, I must report that change to the county health department (CHD) within 30 days of that change. I understand that the CHD will verify the income information I provide. I understand that any intentional false or misleading statement by me can be charged as a second degree misdemeanor and will result in my loss of eligibility for this program.

_____ _____
Signature of Applicant Date

ELIGIBILITY DETERMINATION: TO BE COMPLETED BY CHD EMPLOYEE OR DESIGNATED AGENT

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

_____ 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.s

_____ is not eligible for the Insulin Distribution Program.

_____ _____ _____
Signature of CHD Employee or Designated Agent | Date of Eligibility Determination | Date of Eligibility Expiration (one year from determination date)

EMERGENCY ISSUANCE: TO BE COMPLETED BY CHD EMPLOYEE OR DESIGNATED AGENT

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 or Designated Agent Date

CLIENT REMINDER

Diabetes self- management education received. _____YES _____NO

DH 2105, 3/07 (obsoletes previous editions)
Side 1
Stock Number: 5744-000-2105-5

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.

ELIGIBILITY DETERMINATION

Determine the applicant's eligibility based on the criteria below:

- Is a bona-fide resident of Florida.
  An illegal alien that lives in Florida with the intent to remain meets the residency requirement for the Insulin Distribution Program. The program does not include a requirement to establish citizenship or alien status.
- Has a current prescription for insulin.
- Is uninsured or is lacking insurance that covers insulin.
- Has a net family income at or below 100% of the poverty guidelines.
  If the applicant's dwelling place includes more than one family or more than one unrelated individual, the poverty guidelines shall be applied separately to each family or unrelated individual and not the dwelling place as a whole.
- Has no more than $2,500 in private funds, bank accounts, or assets other than a homestead.

Document Florida residency, insurance status, and assets by self-declaration. Verify income as follows:

(1) Applicants shall be required to sign a self-declaration statement of income, specifying all gross income available to the applicant and the number of people dependent upon that income.

(2) The self-declaration statement shall include a signed acknowledgement that the statement is true at the time it is made and that the person making the statement understands that the CHD will attempt to verify the statement.

(3) Verification may be by telephone, in written form, or by face-to-face contact. Verification does not require written documentation to confirm an applicant's statement. Examples of verification include:
  (a) A statement from a state or federal agency which attests to the applicant's financial status.
  (b) A statement from the applicant's or family member's employer.
  (c) Pay stubs for four consecutive weeks.
  (d) A statement from a source providing unearned income to the applicant or family unit.

(4) If the CHD is unable to verify wages paid or an employer will not verify wages paid, the self-declaratory statement provided by the applicant may be accepted as accurate.

(5) If the applicant declares zero income, the CHD may require the applicant to describe in detail their living circumstances and how they obtain basic necessities such as food, shelter, clothing, medical care, and transportation.

DIABETES SELF-MANAGEMENT EDUCATION CLIENT REMINDER

CHD staff are encouraged to use the opportunity presented in the process of distributing insulin to a client to ask the client if he/she has attended a diabetes self-management education (DSME) class. Indicate on the form whether or not the client has attended DSME. If the client has not attended a class, CHD staff should provide the client with information on classes available in the county. This information can be obtained from the chronic disease prevention coordinator at the CHD or from the American Diabetes Association website: www.diabetes.org/education/eduprogram.asp.

The American Diabetes Association identifies DSME as the cornerstone of care for all individuals with diabetes who want to achieve successful health outcomes. According to the American Diabetes Association's 2006 Standards of Medical Care:

- DSME is an integral component of care for people with diabetes.
- People with diabetes should receive DSME when their diabetes is diagnosed and as needed thereafter.
- Several studies have found that DSME is associated with improved diabetes knowledge, improved self-care behavior, improved clinical outcomes such as lower A1C, lower self-reported weight, and improved quality of life.

If possible, the client should be provided with a Diabetes Health and Care Diary to keep a record of services needed and received. The diary can be ordered from the Diabetes Prevention and Control Program website at: http://www.doh.state.fl.us/family/dcp/OrderForm.pdf