Insulin Distribution Program Application

APPLICANT INFORMATION – PLEASE PRINT

Name: _____ _____ _____
Last First Client I.D. Male or Female

Mailing Address: _____ _____ _____
(Must be a street address.) Telephone Date of Birth

_____ _____ _____ _____
City County State Zip

I am presently a Florida resident. I intend to remain a resident of Florida. _____ Yes _____ No

I have diabetes and require insulin. (Prescription attached.) _____ Yes _____ No

I do not have Medicaid or health insurance that covers insulin, or I have an insurance co-pay or deductible I cannot afford. _____ Yes _____ No

My annual net family income is $_____.

There are _____people in my family.

My assets, other than my homestead, are below $2,500. _____ Yes _____ No

MEDICAL INFORMATION

Do you have any known allergies/drug reactions? _____ Yes _____ No

If yes, please name the drug(s):

_____

List prescription medication(s) you are now taking which were not received from Central Pharmacy:

_____

List Over-the-Counter medication(s) you are now taking:

_____

Please check if you have any of the health conditions listed below:

_____Arthritis
_____Ulcers
_____Diabetes
_____Cancer
_____Epilepsy
_____Asthma
_____Heart Conditions
_____Kidney Disease
_____Lung Disease
_____Rheumatic Fever
_____Tuberculosis
_____Liver Disease
_____Blood Clotting Disorders
_____High Blood Pressure
_____Parkinson's Disease
_____Anemia
_____Pregnancy
_____Other _____

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 90 days of that change. I understand that the CHD may 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.

Please mail my prescription to: _____ my home address above or _____ the CHD at _____

_____

_____ _____ _____
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

☐ 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 http://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html#Florida or http://professional.diabetes.org/erp_zip_search.aspx

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
- 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

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
- 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:

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