Health PEI

PEI Insulin Pump and Glucose Sensor Program — INITIAL

Family Contribution Assessment and Release of Information

		or (check all that apply):	۲	Pump s	upplies	□G	lucose sen	sors
		ires the above listed de	evices (Pl	<u>-</u>	<u> </u>		144000	
Last Name				First Name			Middle Initia	nl
PHN #				DOB				
Address (Ma	iling ad	dress)						
Street # and I	Name						Apt#	
City / Town					Province		Postal Code	
Cell phone		()			Home phone	()		
Email address	to comn	nunicate with Program Adm	ninistrato	r				
If the above	named	individual is <u>under age</u>	<u>19</u> , plea	se indicate liv	ing arrangements	5:		
Both par	ents	Mother only	Father or	nly Othe	r (specify)			
• Par	ents/ G	uardian are to complete	e Section	n A on Page 2				
If the above	named	individual is age 19 or	over, pl	ease indicate	current status:			
		uding widowed or	divord	ced)		☐ Marrie	ed/Commo	n law:
 If single are you a full-time student? If YES: The young adult who is a full-time student, please sign the consent below The parent / guardian (s) of the full-time student (i.e. the dependent) are to complete Section A on page 2. 						ion B on		
• If NO:		rectly to Section B on pa						
	•	11: 140: 0		, .				
If you are <u>liv</u> o you o your	ring as a must re parent n adult,	a adult aged 19 to 2 dependent (ex: high so eview / sign the consent / guardian must compl you must sign the Rele	chool or below, ete Sect ase of Ir	university stu- giving permiss tion A on page	dent, full time): sion for your pare 2 and sign the D nsent on page 5 a	ent / guardian eclaration on and the Gluco	page 4 se Sensor Agre	eement on
',(pr	int name		'	 mm/dd)	being 15 year	3 Of age of C	naer, consen	t to my
(print name) (yyyy/mm/dd) parent/s making this application on my behalf for funding assistance under the PEI Glucose Sensor Program								
Signature of Young Adult (yyyy/mm/dd)								
Please m	Please mail *completed application to: Toll Free Contact information:							
Insulin Pump Program Administrator 1-833-335-0538								
Health P	EI, 16	Garfield Street,			diabetes	<u>sadminoffic</u>	er@ihis.org	
	Charlottetown, PE, C1A 6A5							
454	*Faxed or electronic /scanned copies will <u>not</u> be accepted							

SECTION A:							
Household Information for Applicant on behalf of a Dependent (Under age 19 or a full time student aged 19 to 24)							
Parent / Legal Guardian of individual noted on page 1							
Last Name		First Na	ame			Middle Initial	
Social Insurance Number				Date of birth			
Spouse / Partner (Of Pare	ent / Legal Guardian)						
Last Name		First Na	ame				
Social Insurance Number				Date of birth			
Address of parent/ guard	dian Same as no	ted on page	1				
Street # and Name						Apt #	
City / Town				Province		Postal Code	
Cell phone ()			Home Telephone	()		
Email Address							
Does the parent/ guardia	an, or spouse / partne	er have:					
Third party health insurance of insulin pump and pump su Third party health insurance	upplies?		Yes		ou answered "N tions proceed to p		
of glucose sensors? If "yes" to above, please	nrovide the following	n informatio	nn				
	Ith insurance company	, mormacio					
				your coverage, please c	ontact your insi	urance company to i	nquire
If there is more than one p	plan that provides cover	age, please p	provide in	formation on the add	litional health	plan	
Name of heal	Ith insurance company						
Terms of Coverage For pump, pump supplies and glucose sensors If you are not aware of your coverage, please contact your insurance company to inquire							
If applying for coverage under the Glucose Sensor Program, please answer the following:							
When purchasing glucose se	sensors at your pharmac	y		The pharmacy can direct-bill your insurance company at the time of purchase			
If you are not aware company to inquire	ance	You must pay full cost at the pharmacy and then submit your receipts to your insurance company for reimbursement					

Upon completion of the above section, please proceed to:

- Page 4 Declaration and Consent
- and Page 5 Consent for Release of Personal Health Information
- If you are <u>also</u> applying for coverage under the Glucose Sensor Program, please forward these additional two documents with your application
 - o Page 6: You are to complete Client / Family Agreement for Glucose Sensors
 - Page 7: Your <u>health care provider</u> is to complete Special Authorization Request (only needs to be completed at time of <u>initial</u> application, i.e. not annually)

Personal information, including health information, on this form is collected by Health PEI under the authority of Section 31(c) of the *Freedom of Information and Protection of Privacy Act and/*or the *Health Information Act* for the purposes of determining your eligibility for the Health PEI Insulin Pump Program and the Health PEI Glucose Sensor Program,, for evaluating the program and for other purposes permitted by law. Your information will be collected, used and disclosed only as permitted by law. For more information, visit www.healthpei.ca/yourprivacy or contact the Health PEI Provincial Diabetes Clinical Leader at (902) 368-4243.

SECTION B:											
Household Information for Independent Applicant (Age 19 or over, AND not a full time student)											
Information	of Applicant										
Last Name			First Nan	ne						Middle Initial	
Applicant's So	cial Insurance Number										
Information	of Spouse / Partner (if app	icable)									
Last Name			First N	lame						Middle Initial	
Social Insuran	ce Number						Date of	birth			
Do you or yo	our spouse / partner have:										
Third party health insurance that would cover part or a of insulin pump and pump supplies? Third party health insurance that would cover part or a						Yes Yes		No No	·	ou answered "No' estions proceed to	
of glucose sensors? Name of health insurance company											
Terms of Coverage For pump, pump supplies and glucose sensors				If you are not aware of your coverage, please contact your insurance company to inquire							
If there is mo	re than one plan that provid	es coverage	e, please	provide	info	rmation o	n the add	litional hea	alth p	olan	
ı	Name of health insurance o	ompany									
Terms of Coverage For pump, pump supplies and glucose sensors If you are not aware of your coverage, please contact your insurance company to inquire						inquire					
If applying for coverage under the Glucose Sensor Program, please answer the following:											
When purchasing glucose sensors at your pharmacy			The pharmacy can direct-bill your insurance company at the time of purchase						me		
(If you are not aware, please contact your insurance company to inquire)			You must pay full cost at the pharmacy and then submit your receipts to your insurance company for reimbursement								

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Declaration and Consent

Health PEI

I/We, the undersigned, declare that the information provided on this application is true and correct to the best of my/our knowledge.

I/We, the undersigned, understand that refusing to submit information or knowingly furnishing false or incomplete information is an offence under the *Drug Cost Assistance Act*.

For the purpose of verifying program eligibility, I/we authorize Health PEI to obtain information from:

- My employer, my insurer, and my plan administrator regarding private insurance coverage;
- The Provincial Health Plan (the Plan) regarding my eligibility for health services and release of my PHN;
- Retail pharmacies, to access prescription drug information in order to verify claims

I/We, the undersigned, agree to notify Health PEI of any changes to the household, insurance coverage, or any other factor which may affect my level or eligibility of coverage.

I/We, the undersigned, hereby consent to the release by the Canada Revenue Agency (CRA), of income, expense and identifying information from income tax returns or from other sources, copies of notices of assessment or reassessment, and copies of information slips (for example, T2202A, T3, T4 and T5 slips) filed with CRA. The information will be relevant to, and used solely for the purpose of determining and verifying my eligibility and entitlement for assistance, and collecting overpayments of assistance under the Drug Cost Assistance Programs identified above.

A parent or legal guardian may provide consent for all dependents under the age of 18.

This authorization is valid for the two taxation years preceding the date of this application, the current taxation year and each subsequent consecutive taxation year for which I apply for assistance under the Drug Cost Assistance Programs identified above.

I understand that there are risks associated with sending personal health information to an unsecured email address, including a risk that my information could be accessed by someone else in transit. I accept

Name of Applicant	Signature	Date (yyyy/mm/dd)
Name of Spouse (if applicable)	Signature	Date (yyyy/mm/dd)

By signing above I certify that the information given on this application and in any documents attached is correct, complete, and fully discloses my household conditions.

I understand that a false statement constitutes fraud and may result in recovery of any benefits paid.

I acknowledge that it is my responsibility to report any change to the information provided within 30 days of the change coming into effect.

Name of insulin pump user:	PHN	

Consent for Release of Personal Health Information Insulin Pump Program

Health PEI

Personal health information is required to be released to key partners as part of the business process and continuous quality improvement of the Insulin Pump Program. Personal health information will be used and disclosed only for:

- assessing, verifying and approving eligibility for the program
- the administration, monitoring and evaluation of the program
- facilitating communication between the pump / pump supplies vendor, Health PEI and the applicant

These partners include the Health PEI Insulin Pump Program Administration Office, the selected pump vendor and their approved subcontractor(s), employees of Health PEI, and the Provincial Diabetes Program to ensure a fair administration, monitoring and evaluation of the program. The collection use and disclosure of your personal health information will be limited to only the information required to manage these specific functions. We are committed to protecting personal health information and will only disclose it as permitted by the *Health Information Act*.

The IPP Administration Office will inform the selected vendor and their approved subcontractor(s) of the family contribution that will be required towards the purchase of the pump and supplies. The vendor and their approved subcontractor(s) will also inform the Administration Office of the mailing address and tracking number of the orders when shipped and report returns or discontinuation of supplies and/or insulin pumps as well as misuse of supplies.

This Family Contribution Assessment Form will be stored in a secure filing system with access limited to authorized users. Precautions are in place to ensure that this information is appropriately secure, in accordance with government and Health PEI guidelines.

As well, all collected information from the necessary application forms, will be entered into a database that may be used within Health PEI, to evaluate the Insulin Pump Program and to identify opportunities for improvement. In addition, the vendors and their approved subcontractors may provide Health PEI with pump device and supply usage information. This data will be kept in a secure database, with access limited to authorized users. The database and all records with the Health PEI Insulin Pump Program, diabetes clinics and the IPP Administration Office will be retained in accordance with the appropriate Health PEI record retention schedule.

The vendor and their approved subcontractor(s) may offer a variety of services such as access to a vendor supported website for personal health information and insulin pump data download and analysis. I /We understand that I/We use these services or resources at my/our own risk and the services and resources are not endorsed in whole or in part by the Government of Prince Edward Island, Health PEI, or the Insulin Pump Program.

If an applicant is less than nineteen (19) years of age, the legal guardian or parent must sign the form.

Name of Parent / Guardian	Signature	Date (YYYY/MM/DD)	
Name of Parent / Guardian	Signature	Date (YYYY/MM/DD)	
Name of applicant if adult	Signature of adult applicant	Date (YYYY/MM/DD)	

Health PEI

Name of Client (print)

Name of Parent / Caregiver (print)

If under age 19:

Client/ Family Agreement for Glucose Sensors

Note: In this Agreement, "I" refers to the individual, (and/or the parent/ quardian, as appropriate) who will be using the glucose sensor; wish to apply for benefits under the Health PEI Glucose Sensor Program. Please check ($\sqrt{\ }$) each box to indicate you have read and agree with each statement. I am under the care and management of a primary care provider (doctor/ NP), physician specialist or Certified Diabetes Educator (or Health PEI Provincial Diabetes Program Diabetes Educator) I am knowledgeable in how to use the sensor appropriately I have knowledge of what sensor technology can do and how it can benefit my diabetes care I am willing to use the sensor properly and to use the data from this technology to make safe and effective diabetes management decisions I am willing to share my sensor information with my healthcare team to optimize my diabetes management I am prepared to attend regular follow-up appointments with my diabetes care provider / diabetes team. I am aware that I have to reapply annually by July 1st each year or my benefits under this program will cease. Prior to reapplying I must have submitted my income tax return to Canada Revenue Agency for the previous year. **Preferred method of communication with Program Administrator:** Via email at the following address: Via regular mail at the address provided on the first page

Client signature (if age 19 and over)

Name of Parent / Caregiver (signature)

Date (yyyy/mm/dd)

Date (yyyy/mm/dd)

Health PEI

REQUESTER'S SIGNATURE (REQUIRED)

SPECIAL AUTHORIZATION REQUEST

DATE:

HEALTH CARE PROVIDER: PLEASE COMPLETE ALL SECTIONS. INCOMPLETE APPLICATIONS WILL BE RETURNED

Glucose Sensor Program

This form must be completed by your <u>Health Care Provider</u> i.e. Physician / Nurse Practitioner or Certified Diabetes Educator (or Health PEI Provincial Diabetes Program Diabetes Educator) and submitted with your completed application.

SECTION 1 – PATIENT INFORMA	ATION			
PERSONAL HEALTH NUMBER (PHN)		PATIENT (FAMILY) NAME		PATIENT (GIVEN) NAME(S)
DATE OF BIRTH (YYYY/MM/DD)		PATIENT'S MAILING ADDRESS	,	
Section 2 – Requester's Informa	ntion			
NAME AND MAILING ADDRESS				TION DATE YYYY MM DD TER'S TELEPHONE #
				TER'S FAX #
Section 3- Sensor Detail Informa	tion as per Health	Canada approval		
REQUESTED SENSOR			T	
Freestyle Libre (choose one) Libre or Libre 2 For patients age 4 and over Sensor wear time = 14 days Dispense period = 28 days	ents age 2 and over wear time = 10 days e period = 30 days	□_M :	ledtronic For patients age 2 and over Sensor wear time = 7 days Dispense period = 35 days	
Section 4- Type of insulin thera	ру			
Insulin Pump brand: Medtronic Tandem Omnipod		Numbe	cify below) r of injections per day r of injections per day	
Section 5- Confirmation of Eligi	bility - initial and r	enewal		
Patients must meet the following criteria for For the treatment of patients who are on multiple. The patient is under the care & man The patient demonstrates the capacing The patient demonstrates a reasonate The patient affirms a willingness to under the comments of the patient affirms a willingness to under the care a will be a willingness to under the patient affirms a will be a willingness to under the patient affirms a will be a will b	or special authorization: ciple daily injections of insections of insections of insections of insections of insections of the sensor appropriate the sensor app	sulin (3 or more injections / day) (re provider, physician specialist ropriately at sensor technology can do an	or CDE /	Health PEI PDP diabetes educator
been discussed with the patient / caregiver. Name of Health Care Provider			·	t no longer meets the eligibility criteria. This has
Signature of Health Care Provider				
Health PEI may request additional documentation by Health PEI under the authority of Section 31(c determining your eligibility for the PEI Glucose Seused and disclosed only as permitted by law. For (902) 368-4243.	e) of the <i>Freedom of Informat</i> ensor Program, for evaluating	tion and Protection of Privacy Act ar g the program and for other purpose	nd/or the He es permitted	alth Information Act for the purposes of by law. Your information will be collected,

Please retain this page for information purposes

How do we define "Household"?

A household means a person, the person's spouse, if the person has a spouse, and any dependents. No person may be considered to be part of more than one household.

How do we define "Spouse"?

A spouse is a person who is married to you or with whom you are living in a marriage-like relationship. A spouse may be of the same gender.

How do we define "Dependent"?

A dependent is a child of a person or the person's spouse, who

- is under 19 years of age and does not have a spouse, or
- is 19 years of age or over but under 25 years of age, is a full-time student and does not have a spouse;

What if I am single, 19 years of age or over and still living with my family?

If you are 19 years of age or over, and **NOT** a full-time student, you must complete your own registration form. If you live with your parents, are NOT a full-time student and do not have a spouse or dependents, you are a family of one for our purposes. Do not include your parents' names or their incomes on your registration form

How do we define "Household Income"?

Household income means the total income of the persons in a household, other than any dependents. For each household member, use Line 15000 (Total Income) from the preceding year's tax return, and deduct any amounts reported on lines # 21000 (Split—Pension Amount), # 21400 (Child Care Expenses), # 22000 (Support Payments Made). This amount represents each individual's income for the purpose of Drug Program coverage. Add together the individual amounts for each household member identified above to determine total household income.

How do we calculate coverage under the Insulin Pump Program?

Take the household income you just calculated; determine which income range you fall under:

Total Household Income Ranges	Percentage of Coverage
\$0 to \$20,000	100%
\$20,001 to \$40,000	95%
\$40,001 to \$50,000	90%
\$50,001 to \$100,000	70%
\$100,001 and above	60%

How do we calculate coverage under the Glucose Sensor Program?

Take the household income you just calculated; determine which income range you fall under:

Total Household Income Ranges	Estimated co-pay per dispense to be paid at any PEI Pharmacy (every 26 to 35 days depending on sensor type)			
	No private insurance	With private insurance*		
\$0 to \$20,000	\$0.00	\$0.00		
\$20,001 to \$40,000	\$10.00	\$2.00		
\$40,001 to \$50,000	\$20.00	\$4.00		
\$50,001 to \$100,000	\$60.00	\$12.00		
\$100,001 and above	\$80.00	\$16.00		

^{*} If you have private health insurance that provides partial coverage for glucose sensors, your co-payment will be either 20% of the standard copay (as noted in the table above) or the amount